MEDICAL POLICY

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MEDICAL POLICY DETAILS	
Medical Policy Title	**Cosmetic and Reconstructive Procedures**
Policy Number	**7.01.11**
Category	**Contract Clarification**
Original Effective Date	**12/02/99**
Committee Approval Date	**07/25/02, 12/11/03, 05/27/04, 12/02/04, 12/01/05, 12/07/06, 10/24/07, 10/23/08, 10/28/09, 12/09/10, 12/08/11, 09/04/12, 12/06/12, 12/12/13, 12/11/14, 12/10/15, 02/25/16, 04/27/17, 02/22/18, 02/28/19, 02/27/20, 10/22/20, 02/25/21, 02/17/22, 02/16/23**
Revised Effective Date	**02/16/23**
Archived Date	**N/A**
Archive Review Date	**N/A**
Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program(DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Cosmetic procedures are performed to reshape structures of the body, to improve the patient's appearance and self-esteem. Cosmetic procedures are considered **not medically necessary**.

II. If a medical condition results from a cosmetic procedure, medically necessary services required to treat the medical condition will be **eligible for coverage**. Common, anticipated, side effects (e.g., nausea and vomiting that results in a prolonged hospital stay) are considered part of the cosmetic procedure and are **ineligible for coverage**.

III. Reconstructive procedures are performed on structures of the body affected by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.
   A. Reconstructive procedures incidental to or following surgery to treat an accidental injury, infection or other disease of the part of the body involved**,** and that correct a functional deficit*, are considered **medically appropriate**. Supportive documentation is required.
   B. Reconstructive procedures related to a congenital disease or anomaly of a child that has resulted in a functional deficit* are considered **medically appropriate.** Supportive documentation is required.

*Functional deficit is defined as:
   A. Pain or other physical deficit that interferes with activities of daily living; or
   B. Impaired physical activity.

Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services.

POLICY GUIDELINES

The chart below provides examples of procedures that are generally, although not always, considered to be cosmetic.

When procedures are intended to improve impaired function, coverage will be considered. Adequate documentation must be provided upon request and prior to performing the procedure. This may include photographs, copies of consultations, and any other pertinent information.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Abdominoplasty		Refer to Corporate Medical Policy #7.01.53 Abdominoplasty and Panniculectomy.
Acne: acne cysts, comedone extraction *Refer to Chemical Peel section regarding chemical peel for acne.*	10040 11900-11901 17340 **(E/I)**	Intralesional injection of painful acne cysts is considered **medically appropriate**. Surgical drainage of painful acne lesions (acne surgery) is considered **medically appropriate**. Comedone extraction is considered **not medically necessary**. The use of cryotherapy (carbon dioxide [CO_2] slush, liquid nitrogen) is considered **investigational** in the treatment of acne, due to the lack of peer-reviewed published studies supporting the efficacy of this treatment. Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions.
Actinic keratoses	Refer to benign skin lesion codes.	The use of surgical or medical treatment methods, including, but not limited to: cryosurgery, curettage, and excision, is considered **medically appropriate**. Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions.
Alopecia		Refer to Corporate Medical Policy #2.01.36 Alopecia (Hair Loss).
Benign skin lesions *This section does not refer to skin tags. Refer to Skin Tag Removal section.*	11300-11313 (code range) 11400-11471 (code range) 17110-17111	When removed due to bleeding, pain, recent changes in color, enlargement, or exposure to frequent irritation, removal of benign skin lesion(s) is considered **medically appropriate**. When removed to improve appearance, the removal of benign skin lesion(s) is considered **not medically necessary**.
Blepharoplasty		Refer to Corporate Medical Policy #7.01.55 Blepharoplasty with or without Levator Muscle Advancement.
Breast Asymmetry	19318 19325	Reduction mammoplasty/augmentation mammaplasty for: Treatment of severe asymmetry when functional deficit is documented is considered **medically appropriate**. Surgery and reconstruction of the patient's other breast to produce a symmetrical appearance post-mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) is considered **medically appropriate** and covered as required under applicable law. Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery. Treatment of other cases of asymmetry is considered **not medically necessary**.

Indication/ Procedure	Code(s)	Coverage Criteria
		Treatment of other cases of breast augmentation is considered **not medically necessary.** Refer to Corporate Medical Policy #7.01.39 Reduction Mammaplasty.
Breast implants		Refer to the nationally recognized InterQual criteria. For procedures related to gender reassignment/gender affirmation, refer to Corporate Medical Policy #7.01.84 Gender Reassignment/Gender Affirming Surgery and Treatments for Commercial and Medicare Advantage Members
Breast reconstruction		Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery.
Breast reduction		Refer to Corporate Medical Policy #7.01.39 Reduction Mammaplasty. Refer to the nationally recognized InterQual criteria for Reduction Mammaplasty, Male.
Chemical peel	**All are NMN:** 15788-15793 (code range) 17360	Chemical peel of any body area, including to improve acne, acne scars or uneven pigmentation, is considered cosmetic and, therefore, **not medically necessary**.
CoolSculpting (may also be known as cryolipolysis or fat freezing)		CoolScuplting or fat freezing is considered cosmetic and, therefore, **not medically necessary.**
Comedone extraction		Refer to Acne section.
Congenital chest wall deformity (e.g., pectus excavatum, pectus carinatum)	21740 21742 21743	For reconstructive breast surgery after surgical mastectomy, including partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) for benign or malignant disease, refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery. Surgical correction of a congenital chest wall deformity is considered **medically appropriate** when a documented functional deficit exists. Functional deficits may include, but are not limited to: atypical chest pain, cardiac abnormalities, pulmonary impairment, and, for those with pectus excavatum, a pectus index/Haller score of 3.25 or greater. Surgical correction of a congenital chest wall deformity for cosmetic reasons is considered **not medically necessary**.
Congenital protruding ears	69300	Otoplasty is considered **medically appropriate** when a functional deficit is documented and when the distance from helical rim to mastoid is greater than or equal to 2.1 cm (normal is 1.5-2.0 cm).

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Dermabrasion	15780-15783 (code range)	Dermabrasion is considered **medically appropriate** following traumatic injury, previous surgery, or burns, when a functional deficit exists. Dermabrasion for acne, acne scars, or uneven pigmentation is considered **not medically necessary**.
Dermatoscopy, dermoscopy	96904	Refer to Optical Diagnostic Evaluation of Skin Lesions section.
Ear Piercing Traumatic laceration of ear and/or body piercing	69090 **(NMN)** 12001 12011	Ear piercing is considered cosmetic and, therefore, **not medically necessary** due to lack of a functional deficit. Repair, immediately post-injury, of traumatic laceration of ear and/or body piercing is considered **medically appropriate**. Earlobe repair, or repair of a body site piercing, to close a stretched, pierce hole in the absence of a traumatic injury is considered cosmetic and, therefore, **not medically necessary**.
Eczema		Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions.
Glabella (frown lines)	15826 **(NMN)**	Excision or correction of glabella is considered cosmetic and, therefore, **not medically necessary** due to lack of a functional deficit. Refer also to Rhytidectomy section.
Grafting of autologous fat/tissue	All are **NMN**: 15769 15771 15772 15773 15774	When performed for cosmetic reasons, grafting of autologous fat or tissue is considered **not medically necessary**. Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery
Hair removal for Hirsutism/ Hypertrichosis		Refer to Corporate Medical Policy #2.01.38 Treatment of Hirsutism/Hypertrichosis (Hair Removal).
Hairplasty (hair transplant)	15775 **(NMN)** 15776 **(NMN)**	Hairplasty is considered **not medically necessary**. Refer to Corporate Medical Policy #2.01.36 Alopecia (Hair Loss).
Hemangioma		See Port Wine birthmark section.
Hyperhidrosis surgery: includes endoscopic transthoracic sympathicotomy/ sympathectomy (ETS), sympathectomy (radial artery,	32664 64821-64823 97033 **(E/I)**	Surgical treatment of primary hyperhidrosis is considered **medically appropriate** only in the small subset of patients with medical complications such as skin breakdown with secondary infections (e.g. folliculitis or cellulitis requiring treatment with systemic antibiotics, or fissuring or cracking) or documented significant biopsychosocial functional impairments (e.g., agoraphobia requiring mental health intervention) with documentation of functional deficit, when **ALL** of the following criteria are met:

Indication/ Procedure	Code(s)	Coverage Criteria
ulnar artery, superficial palmar arch), video assisted thoracic sympathectomy (VATS), and surgical excision of axillary sweat glands.		Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash; AND Patient is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anti-cholinergics, beta-blockers, or benzodiazapines); AND Patient has failed to adequately respond to treatment with botulinum toxin A (Botox A). Treatment of hyperhidrosis for cosmetic reasons is considered **not medically necessary**. The following treatments for hyperhidrosis are considered **investigational** because they have not been proven to be effective: acupuncture, axillary liposuction, homeopathy, hypnosis, iontophoresis, massage, psychotherapy, and phytotherapy (use of extracts from natural origin as medicines).
Keloid scars	See excision of benign lesion codes.	Treatment of keloid scars (including steroid injections, excision, and adjunctive post-operative radiation therapy) for significant functional deficit such as pain or ulceration is considered **medically appropriate**. Treatment of keloid scars for nonfunctional reasons is considered **not medically necessary**.
Labiaplasty/ Vulvectomy (e.g., Alter procedure)	56620, 56625	Vulvectomy as part of surgery to treat cancer or pre-cancerous lesions (dysplasia) is considered medically appropriate. Vulvectomy is considered **not medically necessary** for any other indications. Labiaplasty is the reduction of the labia majora (outer lips of the vulva) or labia minora (inner lips of the vulva). Labiaplasty is considered **not medically necessary** when performed for cosmetic purposes. Refer to Corporate Medical Policy #7.01.84 Gender Reassignment/Gender Affirming Surgery and Treatments for Commercial and Medicare Advantage Members
Laser resurfacing or laser scar revision	17999 0479T 0480T	Procedures related to the management of scarring, including post-mastectomy scars, are considered cosmetic, and therefore, **not medically necessary**, unless the scarring results in a functional deficit. Fractional ablative laser fenestration of burn and traumatic scars for functional improvement is considered **medically necessary** when there is documented evidence of significant functional impairment related to the scar (that is, limited movement) and the treatment can be reasonably expected to improve the functional impairment. Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery.
Lipectomy (includes suction lipectomy, liposuction)	15830 15832-15839	Liposuction for lipedema can be considered a **medically appropriate** treatment option, when **ALL** of the following criteria are met: A. The patient has clinical exam findings that support the diagnosis of lipedema, which may include, but are not limited to:

Indication/ Procedure	Code(s)	Coverage Criteria
	15876-15879	1. bilateral symmetric adiposity in the extremities; 2. non-pitting edema; 3. easy bruising; and 4. tenderness to palpation at affected areas. B. The patient has not responded to at least six consecutive months of optimal medical management (e.g., conservative treatment with compression garments and manual lymph drainage). C. The patient has a significant physical functional deficit (e.g., difficulty ambulating or performing activities of daily living) or medical complication (e.g., recurrent cellulitis). D. The patient's plan of care is to wear compression garments as instructed and continue conservative treatment, post-operatively, to maintain benefits, including weight management. When performed for the sole purpose of removal of fat for nonfunctional reasons, lipectomy is considered **not medically necessary**. However, it may be an integral part of other covered services. This applies to removal of fatty tissue after weight loss for any reason, including bariatric surgery. Refer to the nationally recognized InterQual criteria for Reduction Mammoplasty, Male.
Mastopexy (breast lift for pendulous breasts)	19316	Mastopexy is considered **medically appropriate** when a functional deficit is documented. Mastopexy without functional deficit is considered **not medically necessary**. Mastopexy in post-mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) patients is considered **medically appropriate** and covered as required by applicable law. Refer to Corporate Medical Policy #7.01.39 Reduction Mammaplasty.

Indication/ Procedure	Code(s)	Coverage Criteria
Optical diagnostic evaluation of skin lesions (e.g., complexion analysis, Dermatoscopy/ dermoscopy [Dermascope, Episcope, MoleMax II, Nevoscope], epiluminescence microscopy, incidence light microscopy, melanomagram, multi-spectral imaging [MelaFind], skin surface microscopy, total/whole body photography, Visia)	96904 **(NMN)** 0470T **(NMN)** 0471T **(NMN)**	Optical diagnostic evaluation of skin lesions using direct inspection, photography, digitization of images, or computer-assisted analysis is considered **not medically necessary** as a technique to evaluate or serially assess pigmented skin lesions or to define peripheral margins of skin lesions suspected of malignancy prior to surgical excision. Dermatoscopy, also known as dermoscopy, describes a family of non-invasive techniques that allow in vivo microscopic examination of skin lesions and is intended to help distinguish between benign and malignant pigmented skin lesions. Multispectral digital skin lesion analysis (MSDSLA) uses a handheld scanner to shine visible light on the suspicious lesion. The data acquired by the scanner are analyzed by a data processor, and the characteristics of each lesion are evaluated using proprietary computer algorithms. Literature is inconclusive regarding the clinical role of optical diagnostic evaluation of skin lesions in the management of pigmented skin lesions, either to select or deselect lesions for excision or to define peripheral margins of malignancy prior to surgical excision. There is a lack of evidence that demonstrates the impact of these technologies on clinical outcomes.
Panniculectomy		Refer to Corporate Medical Policy #7.01.53 Abdominoplasty and Panniculectomy.
Port wine birthmark	17106-17108	Treatment, including laser, of congenital port wine birthmark and hemangiomas, when functional deficit is documented, is considered **medically appropriate**. Treatment of congenital port wine birthmark and hemangiomas without functional deficit is considered **not medically necessary**.
Psoriasis		Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions.
Rhytidectomy (face lift)	**All are NMN:** 15824-15829 (Code range)	Rhytidectomy performed for correction of a documented functional deficit from facial nerve palsy is considered **medically appropriate**. Treatments to remove wrinkles for cosmetic reasons, including the use of botulinum toxin (Botox) is considered **not medically necessary**. Refer to the Health Plan Pharmacy Department's policy regarding botulinum toxin (Botox). Also refer to Subcutaneous Injection of Filling Material and Glabella sections.
Rosacea, including erythema and telangiectasia	17106-17108	Treatment of rosacea when there is a documented functional deficit, using procedures such as photoablation, laser treatment, sclerosing injections or ultraviolet light therapy, is considered **medically appropriate**.

Indication/ Procedure	Code(s)	Coverage Criteria
		Treatment of rosacea for cosmetic reasons, using procedures such as photoablation, laser treatment, sclerosing injections or ultraviolet light therapy, is considered **not medically necessary**.
Scar revision		Revision of scars via surgery or intralesional steroid injection is considered **medically appropriate** when scars result in a functional deficit. Revision of acne or other scars for cosmetic reasons is considered **not medically necessary**.
Skin discoloration, including dyschromia		Treatment of skin discoloration when a functional deficit is documented is considered **medically appropriate**. Treatment of skin discoloration for cosmetic reasons is considered **not medically necessary**. Also refer to Vitiligo and to Port Wine birthmark sections.
Skin removal, redundant or excessive skin	Refer to lipectomy codes.	Removal of redundant or excessive skin, including, but not limited to, redundant skin on the arms, thighs, back and buttocks, is considered **medically appropriate** when there is documentation of a significant functional impairment (e.g., cellulitis, abscess, or skin ulceration) that has been refractory to medical therapy (persistent, does not clear up then recur) for at least six months, including a minimum of two 10-day courses of appropriate systemic antibiotic therapy. This includes removal of redundant skin caused by weight loss for any reason, including bariatric surgery. Removal of redundant or excessive skin for cosmetic reasons is considered **not medically necessary**. Removal of redundant skin caused by weight loss for any reason, including bariatric surgery, when there is <u>not</u> a functional deficit, is considered **not medically necessary**, as redundant skin is an expected outcome after significant weight loss; including a *Total Body Lift*. Refer to Corporate Medical Policy 7.01.53 Abdominoplasty and Panniculectomy.
Skin tag removal	11200-11201	When skin tags are located in areas subject to repeated irritation and bleeding, removal may be considered **medically appropriate**. Removal of skin tags for nonfunctional reasons is considered **not medically necessary**.
Spider veins of the face including telangiectasia and stellate angioma		See Rosacea section.
Subcutaneous injection of filling material (e.g., collagen, Hyaluronic acid, Prolaryn, Radiesse,	11950-11954 (Code range) L8607, Q2026, Q2028	Subcutaneous injection of filling material is considered cosmetic and, therefore, **not medically necessary**. Dermal injections with products approved by the U.S. Food and Drug Administration(FDA) (e.g., poly-L-lactic acid [Sculptra], calcium hydroxylapatite [Radiesse]) for facial lipoatrophy syndrome (FLS) are considered **medically appropriate** in HIV-infected patients whose FLS has been caused by antiretroviral HIV treatment.

Indication/ Procedure	Code(s)	Coverage Criteria
Restylane, Sculptra)		Injection with Prolaryn is considered **medically appropriate** as an implant space-filling material for soft tissue augmentation in laryngeal procedures for vocal fold medialization and augmentation. If utilized for breast reconstruction, refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery.
Subcutaneous injection to dissolve unwanted small localized areas of fat (e.g. deoxycholic acid (Kybella))	J0591 (**NMN**)	Subcutaneous injection for the reduction of submental fat (i.e., double chin) or other areas of fat is considered cosmetic and, therefore, **not medically necessary**.
Tattoos (decorative or self-induced), including intradermal introduction of insoluble opaque pigments to correct color defects of skin.	11920-11922	When excision or treatment of tattoos is performed for nonfunctional reasons, it is considered **not medically necessary**. The use of tattoos in breast reconstructive surgery is addressed in Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery.
Varicose veins (including telangiectasia)		For treatments other than vein stripping and ligation, refer to Corporate Medical Policy #7.01.47 Varicosities, Treatment Alternatives to Vein Stripping and Ligation.
Vitiligo	96912	Treatment of vitiligo with autologous epidermal cell transplantation for repigmentation is considered **investigational**. Treatment of vitiligo of non-exposed areas, which may be protected from sun exposure, or treatment of vitiligo for cosmetic reasons, is considered **not medically necessary**. Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions, regarding treatment with therapies such as excimer laser, PUVA, UVB, targeted phototherapy (e.g. XTRAC XL, VTRAC, BClear, Excilite, Excilite *u* and XeCL lamps).
Voice lifting procedures	No code(s)	Voice lifting procedures are performed in order to restore a youthful quality to patients' voices and can be performed with implants to bring vocal cords closer together or injections of fat or collagen to plump cords and restore youthful elasticity. Voice lifting procedures are considered **not medically necessary** due to lack of a functional deficit.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*

- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
Refer to table above.	

HCPCS Codes

Code	Description
Refer to table above.	

ICD10 Codes

Code	Description
Numerous	

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*Key article

KEY WORDS

Acne cysts, actinic keratoses, Activadose, benign skin lesion, chemical peel, complexion analysis, dermabrasion, dermatoscopy, Drionic, eczema, face lift, hyperhidrosis, keloid scars, labiaplasty, lipectomy, liposuction, otoplasty, port wine birthmark, Prolaryn, repigmentation, rhytidectomy, rosacea, scar revision, skin removal, skin tag removal, subcutaneous injection of filling material tattoo removal, voice lift.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There are currently National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) that address various services considered to be cosmetic or reconstructive services. Please refer to the following websites for Medicare Members:

NCDs:
Laser Procedures (140.5):
https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=69&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=laser+procedures&KeyWordLookUp=Title&KeyWordSearchType=And&ncd_id=140.5&ncd_version=1&basket=ncd%25253A140%25252E5%25253A1%25253ALaser+Procedures&bc=gAAAABAAAAAA&.

Treatment of Actinic Keratosis (AKs) (250.4):
https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=129&ncdver=1&NCAId=1&ver=23&NcaName=Actinic+Keratoses&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=actinic+keratoses&KeyWordLookUp=Title&KeyWordLookUp=Title&KeyWordSearchType=And&KeyWordSearchType=And&ncd_id=140.5&ncd_version=1&basket=ncd%25253A140%25252E5%25253A1%25253ALaser+Procedures&bc=gAAAABAAIAAA&.

LCDs:
Debridement Services:
https://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx?from=~/overview-and-quick-search.aspx&npage=/medicare-coverage-database/details/lcd-details.aspx&LCDId=33614&ver=11&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=debridement&KeyWordLookUp=Title&KeyWordSearchType=Exact&kq=true&bc=IAAAACAAAAAA&

Removal of Benign Skin Lesions:

https: www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54602&ver=11&keyword=Removal%20of%20Benign%20Skin%20Lesions&keywordType=starts&areaId=s41&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

There is a National Coverage Analysis Decision Memo for **Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome** (FLS)(CAG-00412N). Please refer to the following website for Medicare members: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=234&NcaName=Dermal+injections+for+the+treatment+of+facial+lipodystrophy+syndrome+(FLS)&NCDId=338&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7CCAL%7CNCD%7CMEDCAC%7CTA%7CMCD&ArticleType=Ed%7CKey%7CSAD%7CFAQ&PolicyType=Final&s=5%7C6%7C66%7C67%7C44&KeyWord=Dermal+Injections+for+the+Treatment+of+Facial+Lipodystrophy+Syndrome&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&IsPopup=y&bc=AAAAAAAACAAAAA%3D%3D&.