MEDICAL POLICY

Excellus

MEDICAL POLICY DETAILS	
Medical Policy Title	**COSMETIC AND RECONSTRUCTIVE PROCEDURES**
Policy Number	**7.01.11**
Category	**Cosmetic**
Effective Date	**12/02/99**
Revised 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**
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 product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.* • *If a Medicare 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.*

POLICY STATEMENT

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

II. If a medical condition results from the 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 which result 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 caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.
   A. *Reconstructive* procedures incidental to or following surgery resulting from accidental injury, infection or other disease of the part of the body involved**,** and that corrects 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 regarding Experimental or Investigational Services.

POLICY GUIDELINES

I. The Federal Employees Health Benefit Program (FEH/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

II. The following are 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 regarding *light and laser treatments* of acne.
Actinic keratoses	Refer to benign skin lesion codes.	When performed using 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 or enlargement, or exposure to frequent irritation, removal of benign skin lesion(s) are 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.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Breast Asymmetry	19318 19324 19325	Reduction mammoplasty /augmentation mammaplasty for: Treatment of severe asymmetry when functional deficit is documented is considered **medically necessary**. Surgery and reconstruction of the other breast to produce a symmetrical appearance post-mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) patients is considered **medically appropriate** *per NY State Law.* Refer to Corporate Medical Policy #10.01.01, Breast Reconstruction Surgery Treatment of other cases of asymmetry is considered **not medically necessary**. 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 Interqual® Criteria. Procedures for the purpose of gender reassignment/gender affirming reasons should refer to Corporate Medical Policy #7.01.84 Gender Reassignment/Gender Affirming Surgery
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.
Chemical peel	**All are NMN:** 15788-15793 (code range) 17360	Chemical peel of any body area, including acne, acne scars or uneven pigmentation, 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	Surgical correction of a congenital chest wall deformity is considered **medically necessary** 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**.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
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).
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.
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 regarding Alopecia (Hair Loss).
Hemangioma		See Port Wine Stain section.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Hyperhidrosis surgery: includes endoscopic transthoracic sympathicotomy/ sympathectomy (ETS), sympathectomy (radial artery, ulnar artery, superficial palmar arch), video assisted thoracic sympathectomy (VATS), and surgical excision of axillary sweat glands.	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: 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 **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). While iontophoresis, using devices such as Drionic® or Activadose™ Controller, may provide temporary relief in the treatment of hyperhidrosis, it is administered using equipment not classified as DME. Therefore, equipment and supplies are not covered under most contracts.
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 (e.g., Alter procedure)	56620, 56625	Labiaplasty is the reduction of the labia majora (outer lips of the vulva) or labia minora (inner lips of the vulva). Labiaplasty is a cosmetic procedure and therefore **not medically necessary**.
Lipectomy (includes suction lipectomy, liposuction)	15830 15832-15839 15876-15879	When performed for the sole purpose of removal of fat for nonfunctional reasons, lipectomy is considered **not medically necessary**. However, these techniques may be an integral part of other covered services. These criteria apply to removal of fatty tissue after weight loss, due to any reason, including bariatric surgery. *Liposuction (e.g., body jet, water assisted - WAL)* is considered **investigational** in the removal of adipose tissue in patients with lipedema as it has not been proven to be effective in peer-reviewed, published literature.

Indication/ Procedure	Code(s)	Coverage Criteria
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** per NY State Law. Refer to Corporate Medical Policy #7.01.39, Reduction Mammaplasty.
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™)	0400T **(NMN)** 0401T **(NMN)** 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 noninvasive 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; 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 to either 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. Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report
Panniculectomy		Refer to Corporate Medical Policy #7.01.53, Abdominoplasty and Panniculectomy.
Port wine stains	17106-17108	Treatment, including laser, of congenital port wine stains and hemangiomas when functional deficit is documented is considered **medically appropriate**. Treatment of congenital port wine stains 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.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Rhytidectomy (face lift)	**All are NMN:** 15824-15829 (Code range)	For correction of a documented functional deficit from facial nerve palsy, is considered **medically appropriate**. Removal of wrinkles is considered **not medically necessary**, including use of Botulinum Toxin (Botox) when used for cosmetic reasons. *Refer to FLRx for the Pharmacy 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**. 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		Treatment via surgery or intralesional steroid injection is considered **medically appropriate** when scars cause a functional deficit. Revision of acne scars or revision of 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 Stains 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., persistent cellulitis, abscess, or skin ulceration) that has been refractory (not recurrent, e.g. clears up then recurs) to medical therapy for at least 6 months, including a minimum of two 10-day courses of appropriate systemic antibiotic therapy. This includes removal of redundant skin caused by weight loss, due to 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 due to any reason, including bariatric surgery, when there is <u>not</u> a functional deficit is considered **not medically necessary** since 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.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
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, Restylane, Sculptra)	11950-11954 (Code range) L8607, Q2026, Q2028	Subcutaneous injection of filling material is considered cosmetic and therefore **not medically necessary**. Dermal injections with FDA approved products (e.g., poly-L-lactic acid [Sculptra], calcium hydroxylapatite [Radiesse]) for facial lipoatrophy syndrome (FLS) are **medically appropriate** in HIV infected patients whose FLS has been caused by antiretroviral HIV treatment. 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.
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.

Indication/ Procedure	Code(s)	Coverage Criteria
Vitiligo	96912	Treatment of vitiligo with autologous epidermal cell transplantation for repigmentation is considered **investigational**. Treatment of vitiligo of non-exposed areas that 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.*

CPT Codes

Code	Description
Refer to table above.	

HCPCS Codes

Code	Description
Refer to table above.	

ICD10 Codes

Code	Description
Numerous	

REFERENCES

Abid I, et al. Pectus Excavatum: A Review of Diagnosis and Current Treatment Options. J Am Osteopath Assoc. 2017 Feb 1;117(2):106-113.

American Academy of Dermatology. Lasers and lights: How well do they treat rosacea? 2017; https://www.aad.org/public/diseases/acne-and-rosacea/rosacea/lasers-and-lights-how-well-do-they-treat-rosacea. accessed 1/24/19.

*American College of Obstetricians and Gynecologists. Committee Opinion 686: Breast and Labial Surgery in Adolescents January 2017 Interim Update replaces 662, May 2016. [https://www.acog.org/-/media/Committee-Opinions/Committee-on-Adolescent-Health-Care/co686.pdf?dmc=1&ts=20170307T0842590534] accessed 1/24/19.

*American Society of Plastic Surgeons. Plastic surgery statistics report. [https://www.plasticsurgery.org/news/plastic-surgery-statistics] accessed 1/24/19.

Bacigalupi RM, et al. Evidence-based, non-surgical treatments for vitiligo: a review. Am J Clin Dermatol 2012 Aug 1;13(4):217-37.

Bae YC, et al. Treatment of recalcitrant port-wine stains (PWS) using a combined pulsed dye laser (PDL) and radiofrequency (RF) energy device. J Am Acad Dermatol. 2017 Feb;76(2):321-326.

*Bassichis B, et al. Injectable poly-L-lactic acid for human immunodeficiency virus-associated facial lipoatrophy: cumulative year 2 interim analysis of an open-label study (FACES). Dermatol Surg 2012 Jul;38(7 Pt 2):1193-205.

*Bauer J, et al. Dermatoscopy turns histopathologist's attention to the suspicious area in melanocytic lesions. Arch Dermatol 2001 Oct;137(10):1338-40.

BlueCross BlueShield Association. Chemical peels. Medical Policy Reference Manual Policy #8.01.16 2018 Dec 13.

BlueCross BlueShield Association. Optical diagnostic devices for evaluating skin lesions suspected of malignancy archived. Medical Policy Reference Manual policy #2.01.42. 2015 Oct 15. Archived

BlueCross BlueShield Association. Laser treatment of port wine stains. Medical Policy Reference Manual Policy #7.01.40. 2015 Nov 12. Archived

BlueCross BlueShield Association. Multispectral digital skin lesion analysis. Medical Policy Reference Manual Policy #2.01.101. 2018 Jan 11. Archived.

BlueCross BlueShield Association. Non-pharmacologic treatment of rosacea. Medical Policy Reference Manual Policy #2.01.71. 2018 Dec 13.

BlueCross BlueShield Association. Reconstructive/cosmetic services – archived. Medical Policy Reference Manual Policy #10.01.09. 2011 Dec 8. Archived

BlueCross BlueShield Association. Treatment of hyperhidrosis. Medical Policy Reference Manual Policy #8.01.19. 2018 Apr 12.

Brodie K, et al. A study of adolescent female genitalia: what is normal? J Pediatr Adolesc Gynecol. 2018 Sep 20. [Epub ahead of print].

Cerfolio RJ, et al. The Society of Thoracic Surgeons expert consensus for the surgical treatment of hyperhidrosis. Ann Thorac Surg 2011 May;91(5):1642-8.

Edwards SJ, et al. Diagnostic accuracy of reflectance confocal microscopy using VivaScope for detecting and monitoring skin lesions: a systematic review. Clin Exp Dermatol. 2017 Feb 20.

Fink C, Jaeger C, Jaeger K, et al. Diagnostic performance of the MelaFind device in a real-life clinical setting. J Dtsch Dermatol Ges. Apr 2017;15(4):414-419.

*Glaser DA, et al. A randomized, blinded clinical evaluation of a novel microwave device for treating axillary hyperhidrosis: the dermatologic reduction in underarm perspiration study. Dermatol Surg 2012 Feb;38(2):185-91.

*Guix B, et al. Treatment of keloids by high-dose-rate brachytherapy: a seven-year study. Int J Radiat Oncol Biol Phys 2001 May 1;50(1):167-72.

Gupta AK, et al. Interventions for actinic keratoses. Cochrane Database Syst Rev. 2012 Dec 12;12:CD004415.

*Huang PS, et al. Cryogen spray cooling in conjunction with pulse dye laser treatment of port wine stains of the head and neck. Chang Gung Med J 2001 Aug;24(8):469-75.

*Jaroszewski D, et al. Current management of pectus excavatum: a review and update of therapy and treatment recommendations. J Am Board Fam Med 2010 Mar-Apr;23(2):230-9.

Koçdor P and Tulunay-Uğur ÖE. Injection laryngoplasty outcomes in vocal fold paralysis using calcium hydroxylapatite. Kulak Burun Bogaz Ihtis Derg 2014 Sep-Oct;24(5):271-5.

Koelink CJ, et al. Diagnostic accuracy and cost-effectiveness of dermoscopy in primary care: a cluster randomized clinical trial. J Eur Acad Dermatol Venereol 2014 Nov;28(11):1442-9.

Li C, et al. Interventions for the treatment of Frey's syndrome. Cochrane Database Syst Rev 2015 Mar 17;3:CD009959.

Lodder WL and Dikkers FG. Comparison of voice outcome after vocal fold augmentation with fat or calcium hydroxylapatite. Laryngoscope 2015 May;125(5):1161-5.

*MacKie RM, et al. The use of the dermatoscopy to identify early melanoma using the three-colour test. Br J Dermatol 2002 Mar;146(3):481-4.

Mulekar SV and Isedeh P. Surgical interventions for vitiligo: an evidence-based review. Br J Dermatol 2013 Oct;169 Suppl 3:57-66.

*Namba Y, et al. The treatment of port wine stains with a dye laser: a study of 644 patients. Scand J Plast Reconstr Surg Hand Surg 2001 Jun;35(2):197-202.

National Institutes for Health and Care Excellence (NICE). Skin conditions overview. 2017; https://pathways.nice.org.uk/pathways/skin-conditions. accessed 1/24/19.

NY State Insurance Law § 4303(x)(1 RE: Post-Mastectomy Breast Reconstruction Surgery Mandate [http://www.dfs.ny.gov/insurance/ogco2008/rg080718.htm] accessed 1/24/19.

NY State Required Benefits [https://downloads.cms.gov/cciio/State%20Required%20Benefits_NY.PDF] accessed 1/24/19.

*Ogawa R, et al. Postoperative electron-beam irradiation therapy for keloids and hypertrophic scars: retrospective study of 147 cases followed for more than 18 months. Plast Reconstr Surg 2003 Feb;111(2):547-53.

Rokni GR, et al. Effectiveness and safety of topical tacrolimus in treatment of vitiligo. J Adv Pharm Technol Res. 2017 Jan-Mar;8(1):29-33.

Schmeller W, et al. Tumescent liposuction in lipoedema yields good long-term results. Br J Dermatol 2012 Jan;166(1):161-8.

Shen T, et al. A meta-analysis of voice outcome comparing calcium hydroxylapatite injection laryngoplasty to silicone thyroplasty. Otolaryngol Head Neck Surg 2013 Feb;148(2):197-208.

Shuck J, et al. Autologous fat grafting and injectable dermal fillers for human immunodeficiency virus-associated facial lipodystrophy: a comparison of safety, efficacy, and long-term treatment outcomes. Plast Reconstr Surg 2013 Mar;131(3):499-506.

Taieb A, et al; Vitiligo European Task Force (VETF); European Academy of Dermatology and Venereology (EADV); Union Europe´enne des Me´decins Spe´cialistes (UEMS). Guidelines for the management of vitiligo: the European Dermatology Forum consensus. Br J Dermatol 2013 Jan;168(1):5-19.

US Code18 §116. Female genital mutilation [https://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap7-sec116.pdf] accessed 1/24/19.

*van geel N, et al. Modified technique of autologous noncultured epidermal cell transplantation for repigmenting vitiligo: a pilot study. Dermatol Surg 2001 Oct;27(10):873-6.

Waldman A, Bolotin D, Arndt KA, et al. ASDS Guidelines Task Force: consensus recommendations regarding the safety of lasers, dermabrasion, chemical peels, energy devices, and skin surgery during and after isotretinoin use. Dermatol Surg. Oct 2017;43(10):1249-1262.

Wilkie, G amd Bartz, D. Vaginal rejuvenation: a review of female genital cosmetic surgery. Obstet Gynecol Surv. 2018 May; 73(5): 287-292.

Winkelmann RR, et al. Impact of guidance provided by a multispectral digital skin lesion analysis device following dermoscopy on decisions to biopsy atypical melanocytic lesions. J Clin Aesthet Dermatol 2015 Sep;8(9):21-4.

*Zaenglein AL, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2016 May;74(5):945-73.e33.

*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 stain, 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

The Medicare Benefits Policy Manual addresses Cosmetic Surgery in the chapter on General Exclusions from Coverage (Chapter 16, Section 120 Rev.198, 11-06-14). Please refer to the following website for information contained in the manual: http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf.

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/details/article-details.aspx?articleId=54602&ver=8&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Both&s=41&KeyWord=removal+benign+skin+lesions&KeyWordLookUp=Title&KeyWordSearchType=And&kq=true&bc=IAAAACAAAAAA&

There is a National Coverage 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&.