Cosmetic, Reconstructive and Restorative Services Clinical Coverage Criteria

Overview

Cosmetic, reconstructive, and restorative procedures encompass a 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. For some services, photographs will be required.

Related policies:
Gender Affirming Surgery
Orthognathic Surgery
Varicose Veins of the Lower Extremities

Fallon Health Clinical Coverage Criteria

Fallon Health may cover 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 surgical procedures 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.

Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair

Fallon Health Clinical Coverage Criteria for blepharoplasty, blepharoptosis repair, and brow ptosis repair apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for blepharoplasty, blepharoptosis repair and brow ptosis repair for Medicare Advantage and Community Care members.

The Plan requires high quality photographs from the front and affected side with the camera at eye-level and the patient looking straight ahead.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® CP:Procedures, Blepharoplasty, Lower Eyelid (CPT 15820, 15821)
- InterQual® CP:Procedures, Blepharoplasty, Upper Eyelid (CPT 15822, 15823)
- InterQual® CP:Procedures, Ptosis Repair, Brow Ptosis Repair (CPT 67900)
- InterQual® CP:Procedures, Ptosis Repair, Eyelid Ptosis Repair (CPT 67901-67909)

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Rhinoplasty and Septoplasty

Fallon Health Clinical Coverage Criteria for rhinoplasty and septoplasty apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for rhinoplasty and septoplasty for Medicare Advantage and Community Care members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® CP:Procedures, Rhinoplasty (CPT 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462)
- InterQual® CP:Procedures, Septoplasty (CPT 30520)
- InterQual® CP:Procedures: Septoplasty (Adolescent) (CPT 30520)

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Rhinoplasty, specifically for nasal deformities resulting from congenital cleft lip and/or palate

Patients with cleft lip deformities also have distortion of the nose. Cleft lip rhinoplasty (CPT 30460, 30462) is necessary to improve nasal function and correct the distortion. In the case of severe nasal deformity, reconstructive rhinoplasty may be done in the child's early years. However, in other cases it is recommended that the operation be performed in the child's middle teenage years, when the nose has attained its maximum growth. Secondary surgery to achieve optimum reconstruction is common.

Excision or Surgical Planning of Rhinophyma

Fallon Health Clinical Coverage Criteria for excision or surgical planning of rhinophyma apply to all plan members.

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 physical functional impairment associated with rhinophyma, and surgical treatment is considered cosmetic in nature.

Excision or surgical planing of rhinophyma (CPT 30120) using a laser and/or other technique may be considered medically necessary when the following criteria are met:

1. The medical record documentation includes evidence of secondary nasal obstruction that is impairing nasal airflow
2. and the proposed procedure can be reasonably expected to improve nasal airflow by correcting the obstruction.

CPT code 30120, Excision or surgical planing of skin of nose for rhinophyma, includes all maneuvers for use of the laser and knife blade. Therefore, the CO2 laser treatment and shave biopsy are considered inclusive components within CPT code 30120 (CPT Assistant; May 2007).

External Ear Reconstruction

Fallon Health Clinical Coverage Criteria for external ear reconstruction applies to all plan members.

Microtia is a congenital condition characterized by the abnormal development of the external ear during the fetal stage. Its severity varies from minor deformities to the complete absence of the auricle. Management of microtia occurs along a spectrum, escalating from an observational approach and prosthetic ear placement to surgical reconstruction. Over 90% of individuals with microtia also suffer from varying degrees of ipsilateral conductive hearing loss. Additionally, malformations of the external ear can interfere with the ability to wear hearing aids or glasses, which is of particular importance given the high incidence of other concomitant craniofacial or ocular abnormalities (Cuccolo et al., 2019). The management of the conductive hearing loss has implications on microtia reconstruction. If the patient is a candidate for aural atresia repair, It is absolutely critical that surgeons considering atresia repair closely communicate with the surgeon who plans to manage the microtia reconstruction for a coordinated surgical timeline that optimizes outcomes while minimizing complications. Optimal timing for aural atresia reconstruction impacted by the microtia reconstruction technique planned (Truong, et al., 2022). Audiologic testing is therefore important to determine the presence of sensorineural hearing. The goals of a surgical intervention for atresia of the external auditory canal would be to either bypass or correct the conductive deficit. Therefore, repair of the external auditory canal is contraindicated if there is any sensorineural hearing loss (Lipan and Eshraghi, 2011).

Autologous costal cartilage (ACC) is considered the gold standard for auricular reconstruction in microtia due to its biological and mechanical properties, which provide a stable and long-lasting structure. Several techniques have been adopted for auricular reconstruction. This surgery is completed in 2–4 stages, separated in time by 3–4 months, depending on the surgeon's technique. Typically, this starts when the patient is at least six years of age. Reconstruction using Nagata and Firmin techniques is typically offered at later ages when the child had a chest circumference of at least 60 cm, the standard indicator of sufficient rib stock. Synthetic materials have emerged as alternatives to ACC for auricular reconstruction, addressing the issue of donor site morbidity associated with cartilage harvesting. Among these, porous high-density polyethylene (HDPE), commercially known as Medpor (Stryker, Kalamazoo, MI, USA), is one of the most extensively utilized materials (Ali et al., 2017). The HDPE implantation procedure may be performed on younger patients, typically 3 to 5 years. However, the infection and implant extrusion rate in this cohort is higher than in individuals who undergo ACC implantation later. Auricular reconstruction is challenging, often causing complications. The procedure should only be performed by experienced surgery teams.

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.

External ear reconstruction may be medically necessary 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 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

Fallon Health Clinical Coverage Criteria for the treatment of HIV-Associated Lipodystrophy Syndrome apply to Community Care members. Refer to Medicare and MassHealth Variation sections below for coverage criteria for Medicare and MassHealth members.

Effective for dates of service on or after November 8, 2016, the following services are covered for Community Care members, in accordance with Massachusetts General Laws Chapter 176G, Section 4CC, and subject to a statement from the treating physician that the treatment is necessary for correcting, repairing or ameliorating the effects of HIV-associated lipodystrophy syndrome.

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.

Rhytidectomy (Face Lift)

Fallon Health Clinical Coverage Criteria for rhytidectomy apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

CPT 15824, 15825, 15826, 15828, and 15829 are listed as nonpayable in MassHealth Physician Manual (PHY-172 effective 01/01/2025), therefore, rhytidectomy is not covered for MassHealth ACO members.

Rhytidectomy (CPT 15824, 15825, 15826, 15828, 15829) is a surgical procedure to remove redundant (excess) skin from the facial area. This procedure is commonly known as a face lift and is generally considered a cosmetic procedure.

Rhytidectomy documentation must include the evaluation and management note in which the decision to perform surgery was made and notes documenting the functional impairment.

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.

Cleft Lip and Palate Repair

Fallon Health Clinical Coverage Criteria for cleft lip and palate repair apply to Medicare and Community Care members. For MassHealth members refer to MassHealth Guidelines for Medical Necessity Determination for Orthognathic Surgery.

Repair of cleft lip with or without nasal deformity (cheiloplasty) is 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 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 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 is 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 may include nasolabial, oromaxillary, and/or oronasal fistula(s), and maxillary alveolar ridge cleft.

Primary palatoplasty may be medically necessary 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 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 ridge cleft 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 to repair a congenital maxillary alveolar cleft that is causing a physical functional impairment, such as, when the cleft impairs normal dental development.

Some children with cleft palates, with or without cleft lips will be left with a nasolabial, oromaxillary, and/or oronasal 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 to repair a fistula that is causing a physical functional impairment, such as difficulty eating or drinking or when the fistula impairs speech.

Chin Surgery (Mentoplasty/Genioplasty)

Fallon Health Clinical Coverage Criteria for chin surgery apply to Medicare and Community Care members.

CPT 21121 and 21122 are listed as nonpayable in MassHealth Physician Manual (PHY-172 effective 01/01/2025), therefore mentoplasty and genioplasty are not covered for MassHealth ACO members. Refer to MassHealth Guidelines for Medical Necessity Determination for Orthognathic Surgery.

Chin surgery, also known as mentoplasty or genioplasty refers to plastic surgery procedures performed to reshape the chin either by enhancement with an implant or reduction surgery on the bone. Chin surgery is always considered cosmetic when performed as an isolated procedure to address genial hypoplasia, hypertrophy or asymmetry, and is also considered cosmetic when performed with other procedures.

Chin surgery 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. 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.

When performed by a maxillofacial surgeon in conjunction with orthognathic surgery to correct deformities of the jaw, refer to Orthognathic Services Clinical Coverage Criteria.

Augmentation Mammoplasty

Fallon Health Clinical Coverage Criteria for augmentation mammoplasty apply to Community Care members only. Refer to Medicare and MassHealth Variation sections below for coverage criteria for Medicare and MassHealth members.

Augmentation mammoplasty, also known as breast augmentation, is a surgical procedure in which the breasts are augmented or enlarged, usually with implants placed under or over chest muscle. Augmentation mammoplasty to enlarge small breasts or to create symmetry between breasts is considered cosmetic and not medically necessary.

Augmentation mammoplasty (CPT 19325) may be considered medically necessary in the following circumstances:
1. Surgery of the contralateral breast to achieve a symmetrical appearance following mastectomy in accordance with the Woman's Health and Cancer Rights Act (refer to Breast Reconstruction section below for coverage criteria), and

For the treatment of gender dysphoria for members who meet clinical coverage criteria in the Plan's Gender Affirming Surgery policy.

Reduction Mammoplasty

Fallon Health Clinical Coverage Criteria for reduction mammoplasty apply to Community Care members only. Refer to Medicare and MassHealth Variation sections below for coverage criteria for Medicare and MassHealth members.

These criteria do not apply to reduction mammoplasty for the treatment of gender dysphoria. Clinical coverage criteria for reduction mammoplasty for the treatment of gender dysphoria can be found in the Plan's Gender Affirming Surgery policy.

Reduction mammoplasty, also known as breast reduction, is a surgical procedure to remove excess breast tissue and skin. Reduction mammoplasty may be considered medically necessary to relieve a physical functional impairment caused by hypertrophic breasts.

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for reduction mammoplasty (female member) for Community Care members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® Criteria CP:Procedures, Reduction Mammaplasty, Female
- InterQual® Criteria CP:Procedures, Reduction Mammaplasty, Female (Adolescent)

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Mastectomy for Gynecomastia

Fallon Health Clinical Coverage Criteria for mastectomy for gynecomastia apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

Mastectomy (or subcutaneous mastectomy), also referred to as reduction mammoplasty may be considered medically necessary to relieve a physical functional impairment caused by gynecomastia, defined as the presence of an abnormal proliferation of breast tissue in males. In true gynecomastia, the breast enlargement is due to glandular breast tissue; in pseudogynecomastia, the breast enlargement is secondary to fat accumulation; and both glandular and fat tissue are present in mixed gynecomastia.

If breast enlargement is from excess fatty tissue and not glandular hypertrophy, reduction by liposuction (suction-assisted lipectomy) can be used. Breast reduction, however, by liposuction only has not been established as a medically necessary procedure and is considered cosmetic, even when it is used as an adjunctive procedure to contour the anterior chest wall.

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for reduction mammoplasty (male member) for Medicare and Community Care members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® Criteria CP:Procedures, Reduction Mammaplasty, Male
- InterQual® Criteria CP:Procedures, Reduction Mammaplasty, Male (Adolescent)

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Breast Reconstruction

Fallon Health Clinical Coverage Criteria for breast reconstruction apply to Community Care members. Refer to Medicare and MassHealth Variation sections below for coverage criteria for Medicare and MassHealth members.

Breast reconstruction is defined as a surgical procedure that is designed to restore the shape of the breast after surgery, accidental injury, or trauma. It is often considered after a mastectomy or lumpectomy for the purposes of correcting deformity or reestablishing symmetry caused by previous surgery and/or the effects of therapeutic treatments, including radiation. Additionally, breast reconstruction is considered to correct congenital anomalies/chest wall deformities, including those seen in Poland Syndrome; as well as for accidental injury, burns, and trauma.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. The WHCRA, enacted October 21, 1998, amended the Public Health Service Act (PHS Act) and the Employee Retirement Income Security Act of 1974 (ERISA). The WHCRA is administered by the Department of Health and Human Services and the Department of Labor.

The WHCRA applies to group health plans and individual insurance policies. Group health plans can either be insured or self-funded. Coverage cannot be denied based upon the period of time between the mastectomy and the request for reconstructive surgery; because the member had the mastectomy prior to joining a plan; or because the mastectomy was not as a result of cancer. Also, despite the title, nothing in the law limits WHCRA entitlements to women.

Although the WHCRA doesn't specifically mention reconstruction after lumpectomy (partial mastectomy), it is generally interpreted as requiring health insurance plans to cover reconstruction after lumpectomy.

The following services are covered for Community Care members, in a manner determined in consultation with the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed, including but not limited to:
  - Prosthetic implant reconstruction with tissue expander
  - Nipple/areolar reconstruction and/or tattooing
- Surgery of the contralateral breast to achieve a symmetrical appearance, including but not limited to:
  - Mastopexy
  - Reduction mammoplasty
  - Augmentation mammoplasty, with or without prosthetic implant
- Revision of a previously reconstructed breast or revision of a procedure performed on the contralateral breast for medically necessary indications, including but not limited to removal and replacement of prosthetic implants, or to achieve symmetry.
- Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas.

Removal of Breast Implants

Fallon Health Clinical Coverage Criteria for removal of breast implants apply to Medicare and Community Care members. Refer to MassHealth Variation section below for coverage criteria for MassHealth members.

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for removal of breast implants for Medicare and Community Care members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® Criteria CP:Procedures, Removal of breast implants

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Complications related to breast implants may potentially increase over time which could result in the need for removal. Additionally, a breast implant that interferes with the diagnostic evaluation of a suspected breast cancer or interferes with a medically necessary treatment of a known breast cancer may need to be removed.

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.

Mastopexy (Breast Left)

Fallon Health Clinical Coverage Criteria for mastopexy apply to Community Care members. Refer to Medicare and MassHealth Variation sections below for coverage criteria for Medicare and MassHealth members.

Also known as a breast lift surgery refers to a surgical procedure designed to lessen the degree of breast ptosis (sagging). Mastopexy is considered cosmetic and not medically necessary, except when performed in accordance with the Woman's Health and Cancer Rights Act (refer to Breast Reconstruction section above for coverage criteria).

Prophylactic mastectomy

Fallon Health Clinical Coverage Criteria for prophylactic mastectomy apply to all plan members.

Prophylactic mastectomy, also known as risk-reducing mastectomy is the 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.

Surgical repair of inverted nipples

Fallon Health Clinical Coverage Criteria for surgical repair of inverted nipples apply to Medicare and Community Care members.

CPT 19355 is listed as nonpayable in MassHealth Physician Manual PHY-172 effective 01/01/2025 and therefore, surgical repair of inverted nipples is not covered for MassHealth ACO members.

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 (CPT 19355) may be medically necessary 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.

Congenital chest wall deformities

Fallon Health Clinical Coverage Criteria for the surgical repair of congenital chest wall deformities apply to all plan members.

Deformities 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.

Surgical repair of pectus excavatum may be medically necessary when the Haller Index (transverse chest to narrowest anterioposterior diameter) is 3.25 or higher.

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).

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.

Panniculectomy

Fallon Health Clinical Coverage Criteria for panniculectomy apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

Panniculectomy is a surgical procedure to remove excessive skin and subcutaneous tissue from the abdomen. This excessive abdominal skin and subcutaneous tissue is called a panniculus. Panniculectomy does not include relocating the umbilicus or tightening of the abdominal muscles (abdominoplasty). In rare circumstances, plastic surgeons may perform a hernia repair in conjunction with an abdominoplasty or panniculectomy. 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 abdominis repair, which is often part of a standard abdominoplasty (American Society of Plastic Surgeons, Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. 2017).

The severity of a panniculus is graded as (American Society of Plastic Surgeons, Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients. 2017):
Grade 1: Panniculus covers hairline and mons pubis but not the genitals
Grade 2: Panniculus covers genitals and upper thigh crease
Grade 3: Panniculus covers upper thigh
Grade 4: Panniculus covers mid-thigh
Grade 5: Panniculus covers knees and below

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for panniculectomy for Medicare and Community Care members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® Criteria CP:Procedures, Panniculectomy, Abdominal (CPT 15830)

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Medical record documentation of must include all of the following:
1. A summary of the medical and surgical history, including the member's weight-loss history; and
2. Documentation of panniculus causing limitations in ambulation or physical activity; and
3. Documentation of two or more of the following: panniculus interferes with activities or daily living, nonhealing ulceration under panniculus, chronic maceration or necrosis of overhanging skin folds, recurrent or persistent skin infection under panniculus, intertriginous dermatitis of cellulitis, panniculitis that has failed to respond to medical management ≥ 12 weeks; and
4. Photographs confirming the patients' medical condition; and
5. Photographic documentation, frontal and lateral views, of the panniculus, taken within the last 12 weeks; and
6. Other clinical information that the Plan may request.

Suction-assisted lipectomy (liposuction) is often an integral part the surgical removal of excessive skin and is not separately reimbursed.

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.

Abdominoplasty is considered cosmetic and not medically necessary. Abdominoplasty (CPT 15847) is an add-on procedure that cannot be billed alone.

Repair of diastasis recti abdominis is considered cosmetic and not medically necessary.

Scar revision, scar contracture release and keloid excision

Fallon Health Clinical Coverage Criteria for the scar revision, scar contracture release and keloid excision apply to all plan members.

Scar revision for cosmetic purposes, for example, to alter the appearance of the scar is not medically necessary.

Effective for dates of service on or after September 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for scar revision (ICD-10-CM L90.5, L91.0), scar contracture release (ICD-10-CM L90.5) and keloid excision (ICD-10-CM L73.0, L91.0, L94.0).

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® Criteria CP:Procedures, Scar Revision
- InterQual® Criteria CP:Procedures, Scar Contracture Release
- InterQual® Criteria CP:Procedures, Keloid Excision

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Removal of benign skin lesions

Fallon Health Clinical Coverage Criteria for the removal of benign lesions applies to all plan members.

Note: Medicare NCD 250.4 outlines coverage for the treatment of actinic keratosis (AK) diagnosis code L57.0 for Medicare members.

The following are examples of benign skin lesions:
- Sebaceous (epidermoid) cysts
- Skin tags
- Mila (keratin-filled cysts)
- Nevi (moles)
- Acquired hyperkeratosis (keratoderma)
- Papillomas
- Hemangiomas
- Viral warts

Benign skin lesions are common and are frequently removed at the patient's request to improve appearance. Removal of benign skin lesions performed for cosmetic reasons is considered not medically necessary.

There may be instances in which the removal of benign skin lesions is medically appropriate. Fallon Health will, therefore, consider their removal medically necessary and not cosmetic if one for more of the following conditions are present and clearly documented in the medical record:
1. The lesion has one or more of the following characteristics: bleeding, intense itching, pain; change in physical appearance (reddening, pigmentary change, recent enlargement, increase in number of lesions.
2. The lesion has physical evidence of inflammation or infection, e.g., purulence, edema, erythema, etc..
3. The lesion obstructs an orifice.
4. The lesion clinically restricts eye function, for example:
    a. Lesion restricts eyelid function; or
    b. Lesion causes misdirection of eyelashes or eyelid; or
    c. Lesion restricts lacrimal puncta and interferes with tear flow; or
    d. Lesion touches globe.
5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the lesion appearance.
6. A prior biopsy suggests or is indicative of lesion malignancy; or
7. The lesion is in an anatomical region subject to recurrent trauma, and there is documentation of such trauma.
8. Wart removal is not considered cosmetic when any of the criteria listed above are met, or if any of the following clinical circumstances are present:

a. Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding; or
b. Warts showing evidence of spreading from one body area to another, particularly in immunosuppressed patients or warts of recent origin in an immunocompromised patients; or
c. Lesions are condyloma acuminata or molluscum contagiosum; or
d. Cervical dysplasia or pregnancy is associated with genital warts.

Medical records maintained by the physician must clearly document the medical necessity for lesion(s) removal if the Plan is billed for the service. The relevant history and physical finding conforming to the criteria listed above must be made available to the Plan on request.

Operative note(s) for surgical procedures performed in the office location may be contained in the patient's medical record for the date of service or as a separate report maintained within the patient's chart. The operative note for the procedure performed must be of significant detail to support the surgical procedure billed. The surgical technique used should be described. Surgical procedures should include the lesion size(s) location(s) and number. Layered closures should include the length recorded in centimeters. Add together the length of multiple closures from all anatomical sites grouped together in the same code descriptor (see the AMA CPT subsection instructions for Removal of Skin Tags, Shaving of Epidermal or Dermal Lesions, Excisions - Benign Lesions, Repairs (Closures) and Destruction).

The decision to perform a minor surgical procedure is included in the payment for the procedure and should not be reported separately as an E & M services. The Plan will not pay for a separate E & M service on the same day as a minor surgical procedure unless a documented significant and separately identifiable medical service is rendered. The service must be fully and clearly documented in the patient's medical record and a modifier 25 should be used.

Excision of excessive skin and subcutaneous tissue

Fallon Health Clinical Coverage Criteria for excision of excessive skin and subcutaneous tissue apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

Removal of excessive skin and subcutaneous tissue also referred to as 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 excessive skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas, may be medically necessary when all of the following criteria are met:

1. The redundant skin is the result of weight loss of greater than 75 pounds, that has been sustained for at least six months, and if weight loss occurs as a result of bariatric surgery, excision of redundant skin is not covered until at least 18 months after bariatric surgery.
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.
3. The redundant skin is documented in photographs and additional photographs must document the presence of intertriginous rashes, ulcerations, and/or infections.

Suction-assisted lipectomy (liposuction) is often an integral part the surgical removal of excessive skin and is not separately reimbursed.

Subcutaneous injection of filling material

Fallon Health Clinical Coverage Criteria for the subcutaneous injection of filling material applies to all plan members.

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 to repair a distensible scar, when the scar itself is the result of an accidental injury (restorative). 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.)

Autologous fat grafting

Fallon Health Clinical Coverage Criteria for autologous fat grafting apply to all plan members.

Note: these criteria do not apply to autologous fat grafting performed in conjunction with breast reconstruction post-mastectomy. Refer to Breast reconstruction section above.

Autologous fat grafting refers to a procedure where adipose tissue (fat) is harvested from the person who will receive it.

Autologous fat grafting may be considered medically necessary when used to address significant variations from normal caused by accidental injury (restorative).

All other uses of autologous fat grafting are considered cosmetic and not medically necessary.

Abrasion and dermabrasion

Fallon Health Clinical Coverage Criteria for abrasion and dermabrasion apply to all plan members.

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 (CPT 15786, 15787) 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 (CPT 15780, 15781, 15782, 15783) 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).

Note: Medicare NCD 250.4 outlines coverage for the treatment of actinic keratosis (AK) diagnosis code L57.0 for Medicare members.

Hair transplantation

Fallon Health Clinical Coverage Criteria for hair transplantation apply to Medicare and Community Care members. Refer to MassHealth Variation sections below for coverage criteria for MassHealth members.

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

Medicare Variation

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.”

Medicare NCDs related to cosmetic, reconstructive and restorative surgery exist:

- Breast Reconstruction Following Mastectomy (NCD 140.2) - Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason. Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §l862(a)(l0) of the Act.) Coverage criteria for breast reconstruction following mastectomy are fully established by Medicare, therefore, the Plan’s coverage criteria are not applicable.
- Plastic Surgery to Correct Moon Face (NCD 140.4) - The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the patient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or for the improvement of a malformed body member which coincidentally serves some cosmetic purpose. Since surgery to correct the condition of "moon face" which developed as a side effect of cortisone therapy does not meet the exception to the exclusion, it is not covered under Medicare (§1862(a)(10) of the Act). Coverage criteria for plastic surgery to correct moon face are fully established by Medicare, therefore, the Plan’s coverage criteria are not applicable.
- Treatment of Actinic Keratosis (NCD 250.4) - Actinic Keratosis (AK), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer. Various options exist for treating AKs. Clinicians should select an appropriate treatment based on the patient's medical history, the lesion's characteristics, and on the patient's preference for a specific treatment. Commonly performed treatments for AKs include cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy. An alternative approach to treating AKs is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma. Effective for services performed on and after November 26, 2001, Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics. Coverage criteria for the treatment of actinic keratosis are fully established by Medicare; therefore, the Plan’s coverage criteria are not applicable.
- Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (NCD 250.5) - Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Dermal fillers that are not approved by the FDA for the treatment of LDS are nationally non-covered. Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who

manifest depression as a result of their antiretroviral HIV treatments are nationally non-covered. Coverage criteria for dermal injections for the treatment of facial lipodystrophy syndrome are fully established by Medicare; therefore, the Plan's coverage criteria are not applicable.

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 06/23/2025). Coverage criteria for reduction mammaplasty are fully established by Medicare; therefore, the Plan's coverage criteria are not applicable.

Link: LCD Reduction Mammaplasty (L35001)

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

Additional Medicare guidance is available:
- 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 Variation

MassHealth has the following Guidelines for Medical Necessity Determination (MassHealth website search 06/23/2025):
- Guidelines for Medical Necessity Determination for Blepharoplasty, Upper Eyelid Ptosis, and Brow Ptosis Surgery
- Guidelines for Medical Necessity Determination for Rhinoplasty and Septoplasty
- Guidelines for Medical Necessity Determination for Orthognathic Surgery
- Guidelines for Medical Necessity Determination for Breast Reconstruction (includes criteria for removal of breast implants)
- 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

HIV-Associated Lipodystrophy Syndrome
In accordance with MassHealth Transmittal Letter PHY-151 (February 2017), and 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 MassHealth ACO, NaviCare and Summit ElderCare members for the treatment of lipodystrophy associated with or secondary to HIV when the following criteria are met:
1. The member has a diagnosis of HIV or AIDS; and
2. 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
3. The requested procedure can reasonably be expected to treat the specific part of the body affected by HIV-associated lipodystrophy syndrome.

Exclusions

- Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies, including, but not limited to: otoplasty for protruding ears (CPT 69300); ear

piercing; abdominoplasty (CPT15847); diastasis recti abdominis repair; chemical peel (dermal and epidermal); microdermabrasion; scar revision, tattoo removal 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.
- 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.

Excision or Surgical Planing of Rhinophyma
Rhinophyma is a disfiguring overgrowth of sebaceous glands in the nasal tissue that has been associated with severe nasal obstruction and undesirable cosmetic implications. Rhinophyma represents the most severe stage of acne rosacea. Despite acne rosacea occurring at a ratio of 3 females to 1 male, rhinophyma occurs almost exclusively in men, with a male-to-female ratio of 12:1 to 30:1, and most commonly develops during the fifth to seventh decades of life. Additionally, this condition predominantly affects the Caucasian population. While the etiology of rhinophyma is not fully understood, it is thought that hormonal factors, specifically increased androgens in men, play a role in its development. Rhinophyma preferentially affects the tip of the nose, and the dorsum, alae and side walls to a lesser extent. As the nasal skin hypertrophies, the aesthetic subunits of the nose are distorted, merged, and obliterated and excess growth often causing secondary nasal obstruction. Rhinophyma can also present as a serious cosmetic concern for patients, causing significant psychosocial stress, anxiety, and impairment of personal

and professional life resulting in isolation and stigmatization of the person. Facial disfigurement of similar severity is well known to predispose patients to depression and social phobia, in some cases resulting in complete social isolation (Benyo et al., 2021).

Despite a clear need for treatment, there is no current consensus on the gold standard for rhinophyma management. It is acknowledged that medical treatment with isotretinoin or tetracycline is only effective in slowing the progression of early stages of this condition. Radiation therapy played a historical role in the treatment of rhinophyma however, this has fallen largely out of favor, owing to the associated risks of developing secondary malignancies. Currently, surgery remains the mainstay for treatment, with the aim being to provide patients with a good aesthetic outcome and restoring the function to the nose. Surgical approaches include scalpel excision, laser ablation, dermabrasion, electrosurgery, or a combination of the aforementioned techniques. Effectiveness of each of the treatments alone or in combination has not been verified; thus, there is currently no gold standard to treating rhinophymas (Goh et al., 2021).

A standard classification system for rosacea was created by the National Rosacea Society Expert Committee on the Classification and Staging of Rosacea. This classification system describes primary and secondary features of rosacea and recognizes four patterns of signs and symptoms, designated as subtypes (Wilkin et al., 2004).

- Subtype 1: erythematotelangiectatic rosacea, where the clinical features include flushing and persistent central facial erythema (redness) with or without telangiectasia.
- Subtype 2: papulopustular rosacea, characterized by persistent central facial erythema with transient, central face papules or pustules, or both.
- Subtype 3: phymatous rosacea, where thickening of the skin is seen with irregular surface nodularities, and enlargement. This may occur on the nose (rhinophyma), chin, forehead, cheeks or ears.
- Subtype 4: ocular rosacea, characterized by ocular involvement, including inflammation of different parts of the eye and eyelid. It may be found in up to 58% of cases but it is frequently undiagnosed.

Each subtype is further characterized as mild, moderate or severe. In the clinical setting, severity of phymatous rosacea may be rated from 0 to 3, with 1 being patulous follicles but no contour changes, 2 being a change in contour without a nodular component, and 3 indicating a change in contour with a nodular component. Researchers may also note any vascular findings or inflammatory changes.

Over the years, several authors have proposed systems to grade the severity and features of rhinophyma. In 1970, BS Freeman[1] described a classification system that grades rhinophyma by degree of severity. In 1990, Clark and Hanke[2] proposed a classification system based on distribution and degree of involvement of the disease. El-Azhary et al., (1991)[3], proposed a grading system of minor, moderate, and major rhinophyma based on the degree and presence of hypertrophy and lobules present; this grading system is used most often in treatment studies. Most recently, Wetzig et al., 2013,[4] developed the Rhinophyma Severity Index (RHISI), which numerically scales the disease based on degree of skin thickening, presence of lobules and fissures, and secondarily presence of prominent asymmetry, cysts, or vessels (Chauhan et al., 2020).

Rhinophyma Severity Scale (RHISI)

Score*	Description
0	No evidence of rhinophyma

[1] Freeman BS. Reconstructive rhinoplasty for rhinophyma. *Plast Reconstr Surg*. 1970;46(3):265–270.
[2] Clark DP, Hanke CW. Electrosurgical treatment of rhinophyma. *J Am Acad Dermatol*. 1990;22(5 Pt 1):831–837.
[3] el-Azhary RA, Roenigk RK, Wang TD. Spectrum of results after treatment of rhinophyma with the carbon dioxide laser. *Mayo Clin Proc*. 1991;66(9):899–905.
[4] Wetzig T, Averbeck M, Simon JC, Kendler M. New rhinophyma severity index and mid-term results following shave excision of rhinophyma. *Dermatology*. 2013;227(1):31–36.

1 Mild skin thickening
2 Moderate skin thickening
3 Strong skin thickening, small lobules
4 Lobules with fissures
6 Giant Rhinophyma

These grading systems communicate severity of disease but do not guide a particular treatment modality.

In 2017, the American Acne & Rosacea Society published a 5-part series of articles on the management of rosacea. The fourth article in this 5-part series reviews physical modalities, such as lasers and surgical interventions for the management of rosacea that exhibit limited or no response to available medical therapies. Phymatous changes develop in a relatively small subset of rosacea patients, usually those with the papulopustular or erythematotelangiectatic subtypes, and can lead to marked disfigurement. The lower nose (rhinophyma) is the most frequently affected site; however, other sites that can be affected are the chin, forehead, ears, and eyelids. Because there are no known effective medical therapies for fully developed phymatous changes, physical modalities and/or surgical interventions are commonly used with several approaches reported. Approaches for the treatment of rhinophyma include tangential excision, electroscalpel, dermabrasion, laser ablation, scissor sculpting, radiofrequency electrosurgery, and wire loop electrosurgery (Tanghetti et al., 2017).

A transition from a subtyping to a phenotyping approach in rosacea is underway, allowing individual patient management according to presenting features instead of categorization by predefined subtypes. The 2017 global ROSacea COnsensus (ROSCO) panel recommended transitioning from a subtype approach to a phenotype approach for rosacea diagnosis, classification and management, which aligns with those of the National Rosacea Society and the American Acne and Rosacea Society. A phenotype approach allows for rosacea diagnosis and management according to a patient's presenting disease features, rather than grouping into prespecified subtypes, thus individualizing care and optimizing treatment outcomes. It acknowledges the limitations of subtyping, while enabling progression within the field by managing each patient as an individual and is being increasingly incorporated into evidence-based systematic reviews, national treatment recommendations and discussion in the literature. However, a formalized transition is still in its infancy and support is required to promote its widespread uptake (Shaller et al., 2019).

Van Zuuren et al., 2019 conducted a systematic review of randomized controlled trials examining all types of interventions for rosacea based on phenotype. One hundred and fifty-two studies were included (eight references report on two studies), comprising 20,944 participants (mean age 48.6 years). More women (n = 12,575) than men (n = 5,313) were included; sex was not reported in 3,056. Study sample sizes varied from six to 1,299 participants, but most were between 30 and 100. The trials were grouped into 12 categories of interventions: topical brimonidine; topical oxymetazoline; topical metronidazole; topical azelaic acid; topical ivermectin; topical metronidazole, azelaic acid and/or other topical treatments in different treatment arms; oral antibiotics; oral antibiotics combined with topical treatments; oral antibiotics compared with topical treatments; other systemic treatments; laser- and light-based therapies; and other treatments or combined treatments. Surgical therapies including ablative laser therapies have been used with reportedly good results for phymatous rosacea (rhinophyma), but no eligible RCTs were identified. An evidence-based approach is essential in delineating differences between the many available treatments for rosacea.

The overall prevalence of well powered, well-conducted randomized controlled trials in rosacea is increasing, but evidence is still sparse in a number of areas (Schaller et al., 2017). This is exemplified by a 2015 Cochrane review on interventions for rosacea, which found no eligible randomized controlled trials for the treatment of patients with phymatous changes (van Zuuren et al., 2015).

Mild rhinophyma may be responsive to systemic treatment with isotretinoin. Isotretinoin shrinks sebaceous glands, but long-term remission of phymatous changes does not occur when isotretinoin is discontinued. More severe disease with deformity responds best to surgical excision, electrosurgery, and CO2 laser therapy. However, randomized-controlled trials to address treatment of phymatous rosacea (rhinophyma) are lacking (Rainer et al., 2017).

Chauhan et al., 2020 conducted a review of the literature for laser therapy, tangential excision, and the subunit method to evaluate treatment outcomes of rhinophyma. The literature search identified 23 retrospective studies and case series published from 1946 to reporting on a total of 396 patients. The severity of rhinophyma was

Laser therapy is an ablative approach to rhinophyma treatment that can both debulk and contour the nose. Among 12 studies, 247 patients with a mean age of 61 years and minor to major disease (minor, n = 67); moderate (n = 64); and major (n = 87) were treated with a CO2 laser in an average of 1.1 sessions. A total of 18 patients were treated, with a mean age of 62 years, and a total of 1 patient with minor, 12 with moderate, and five with major rhinophyma using the erbium: YAG (Er:YAG) laser in 1.0 sessions. Post-operatively, for patients who underwent CO2 laser therapy, post-operative erythema was reported to last between 6 and 12 weeks, re-epithelialization occurred in 1.4–6 weeks, recurrence occurred in 1.2% of patients (range 0.0%–25.0%), with a 10.5% complication rate and a 2.0% revision rate. Patients undergoing Er:YAG laser therapy had 0% recurrence, complication, and revision rates. Post-operative erythema was minimal between these techniques, and re-epithelialization occurred within 1–4 weeks in patients undergoing Er:YAG laser.

Tangential excision with secondary healing is a common method of treatment. A total of 108 patients underwent cold knife tangential excision among 8 studies. Patients had a mean age of 61 years, treated for minor to major rhinophyma, and all required a single session for treatment. Post-operative erythema was reported in one study and reported to last 6–9 weeks, otherwise no post-operative erythema occurred, and re-epithelialization was reported to occur between 2 and 6 weeks. There was an overall 10.2% recurrence rate, 3.7% complication rate, and 0.0% revision rate. Complete satisfaction was reported in 78%–85% of patients, with 92.51% of patients recommending the surgery. Overall patients had good to excellent results with only three patients reported to have an unacceptable result.

The Shaw scalpel is a thermal scalpel used for excision of rhinophyma; the scalpel is set between 160°C and 200 °C. Vural et al., 2009 describe seven patients (mean age 67 years) who underwent Shaw scalpel excision in a single session. Severity of rhinophyma was not reported. The patients were seen 6 to 8 weeks after surgery for routine follow-up. Complications occurred in 14.3%; however, there were no recurrences or revisions reported. The Shaw scalpel is advantageous for treating rhinophyma when compared with laser or dermabrasion ablative techniques because it preserves a specimen for histopathologic evaluation. One patient in this series had a malignant skin lesion which can coexist within a background of rhinophyma or appear similar to a rhinophymatous lesion.

The subunit method is a surgical technique based on utilizing and enhancing the nasal aesthetic subunits to optimize cosmetic and functional outcomes. Incisions are made along the junctions of nasal aesthetic subunits. Indications for the subunit method include poor nasal contour following previous partial excision, when secondary healing is contraindicated, or modifications to underlying cartilage is needed to correct external valve collapse. Hassanein et al. 2017 conducted a retrospective review of 8 patients who underwent the subunit method between 2013 and 2016. Mean age was 63 years (range 34-72). Average follow-up was 1.6 years (range 0.2-3.7). All patients had interdomal sutures for tip enhancement and 4 patients underwent cartilage grafts to correct external valve collapse. Six patients underwent revisional procedures primarily to modify the scar between the dorsum and tip subunits and no recurrence of disease was noted. Patients undergoing the subunit method should be counseled that operation will likely require 2 stages.

Chauhan et al. 2020 concluded that the subunit method had the highest complication and revision rates followed by CO2 laser therapy. Outcomes between carbon dioxide laser and scalpel

therapy and electrocautery were equivalent. They also concluded that scalpel excision was a cost-effective treatment modality with less post-operative complications; however, it risked poor hemostasis intraoperatively. Patient satisfaction was common post-therapy regardless of the treatment method. Over 89% of patients would recommend undergoing treatment for rhinophyma irrespective of treatment type.

Benyo et al., 2021, conducted a review of the literature on severe rhinophyma requiring operative management for significant cosmetic deformity or nasal obstruction. A total of 26 articles were included in the literature review. Due to variability in study design and outcome measures, formal synthesis of data in the form of a meta-analysis was not possible. Benyo et al. provide a summary and explanation of established and currently described surgical techniques in the management of severe rhinophyma, including the risks and benefits of each, as well as the authors' proposed treatment algorithm. "While mild-to-moderate cases can often be managed in the clinic or outpatient setting, major or severe rhinophyma, must be managed with formal operative intervention to adequately address obstruction and nasal contour deformity. Surgical intervention is often performed in 2 stages: (1) surgical planning of rhinophyma, which involves removal of the excess nasal tissue, and (2) reconstruction and relief of nasal obstruction, representing the functional repair stage of treatment." There are multiple techniques used in the surgical planning of rhinophyma, and decision-making on which technique to use is typically based on the surgeon's preference, as there is no current consensus or gold standard of therapy. Surgical techniques include electrosurgery and electrocautery, cold steel excision (scalpel excision), dermabrasion, CO2 laser, subunit method, and cartilage grafting. Often times various combinations of these techniques are utilized, and an individualized approach is necessary.

- Electrosurgery and electrocautery are widely favored by dermatologic and facial plastic surgeons in the treatment of rhinophyma. While these 2 terms often get used interchangeably, there are subtle differences that should set them apart from one another. Electrosurgery, on the one hand, uses radiofrequency electricity to generate heat in the tissue itself. On the other hand, electrocautery describes application of heat to the tissue from an outside source. A benefit of these surgical modalities is that the excised tissue pieces can be more suitable for histological examination, potentially revealing any underlying malignancies. Histopathology may be difficult with other surgical modalities for excision of rhinophyma, such as CO2 laser, due to immediate tissue destruction.
- Cold steel excision (scalpel excision) in the treatment of severe rhinophyma is a widely favored technique due to the ability to quickly debulk the excess diseased tissue. The goal of scalpel excision is ultimately superficial decortication, or partial excision, of the hypertrophic tissue with retainment of the pilosebaceous tissue, which then serves as the layer allowing for subsequent re-epithelialization.
- Dermabrasion is an exfoliating technique that utilizes a rotating instrument to remove outer layers of skin. This technique can cause extensive bleeding and consequently poor visualization of the surgical field and thus is less often reported as being used as the sole modality for treating rhinophyma. It is most commonly used after initial debulking of excess rhinophymatous tissue to smoothen the skin surface.
- CO2 laser surgery represents a newer treatment option for patients with rhinophyma. The benefit of this treatment modality is control of hemostasis, providing a bloodless operative field. However, patients treated with CO2 laser were more likely to have prolonged postoperative erythema compared to the tangential excision group in the Lazzeri et al. (2013) comparative study (discussed below). Also, in the Lazzeri et al. study there was 1 case of scar contraction and 1 case of hypopigmentation in the CO2 laser group, while no hypertrophic scarring, pain, bleeding, and hypopigmentation were observed with tangential excision. Such postoperative complications with the CO2 laser may be attributed to the deep tissue penetration with the laser, causing damage to the dermis and adnexa, thus increasing scar risk. However, this can also be a complication of scalpel excision, and therefore other pros and cons of each surgical modality must be weighed in deciding which technique to use. While there are many benefits of the CO2 laser, it is ultimately less-commonly used

compared to other modalities due to its high expense, prolonged operative time, and specialized training required for use.

- The subunit methods for treatment of severe rhinophyma uses 6 nasal flaps to provide exposure for removal of rhinophymatous tissue, correction of nasal support, and trimming of excess tissue-expanded skin. The incisions are placed at subunit junctions between the sidewalls and dorsum, dorsum and tip, and alae and sidewalls. The distal nose is then degloved by raising the 6 flaps (2 alar, 2 sidewalls, dorsum, and tip), and rhinophymatous tissue is debulked down to perichondrium.
- The gross deformity of severe rhinophyma and chronic inflammation may potentially weaken the cartilaginous support structures, leading to distortion and obliteration of the aesthetic subunits of the nose. Despite the risk of insufficient nasal patency in severe rhinophyma, there is minimal research on the use of cartilage grafting as a component of surgical treatment. The nasal obstruction symptom evaluation (NOSE) score is a validated screening tool for determining the severity of a person's nasal obstruction and has been validated in many patients with limited nasal patency due to acquired nasal deformity. NOSE scores have been shown to be reliably reduced by roughly 50 points with the use of functional septorhinoplasty. A large systematic review defined normative and symptomatic ranges of NOSE scores as 65 ± 22 and 15 ± 17, respectively, with an average postoperative change to be greater than 40 points.[5] Future research should focus to more objectively quantify the extent of nasal obstruction preoperatively, which could inform surgical decision-making regarding grafting in the setting of severe rhinophyma.

Benyo et al. conclude that each surgical modality in the treatment of severe rhinophyma has its advantages and disadvantages, which must be considered along with severity of disease (i.e. nasal obstruction; cosmetic deformity) when deciding which approaches to implement. Given that each modality demonstrates benefits for different aspects of the surgical planning of rhinophyma, an approach in which a combination of the modalities is used in a stepwise fashion to appropriately address the debulking, hemostasis, contouring, and possible reconstruction, while also aiming to minimize postoperative cosmetic and functional complications is recommended. "Future research should aim to better quantify nasal obstruction pre- and postoperatively to evaluate nasal functional impairment in these patients. This could help guide surgical decision-making and better inform our proposed treatment algorithm."

Lazzeri et al., 2013, compared the results of 67 patients affected by rhinophyma and with treated with either tangential excision (N = 45) or CO2 laser (N = 22) between 1996 and 2011. The tangential excision method involved debulking of the rhinophymatous tissue with a 10-blade scalpel combined with fine bipolar diathermy to cauterize bleeding vessels, as well as mild dermabrasion to achieve final shaping results. Lazzeri et al. reported spontaneous re-epithelialization occurring as early as 6 days after treatment and occurring for all patients within 1 month, which is generally similar to the 2-3-week healing times reported with the use of electrocautery. Lazzeri et al. reported that overall, 92.5% of patients had an excellent self-impression with tangential excision, and 75% felt that the time to return back to social life was sufficient and 17.5% felt that this time was quick. On the other hand, the majority of patients in the CO2 laser group reported that return back to social life was long (78.9%), indicating that healing time may be prolonged with use of CO2 laser compared to cold steel. Both tangential excision and CO2 laser are well-established, reliable procedures for the treatment of rhinophyma that preserve the underlying sebaceous gland fundi allowing spontaneous re-epithelialization without scarring with similar outcomes and high patient satisfaction. However, the CO_2 laser is more capital intensive and results in higher fees compared with the simpler cold blade tangential excision. Lazzeri et al. conclude "In our experience the ease of use, accuracy and precision of the lasers offer is not justified by the increased costs."

[5] Rhee JS, Sullivan CD, Frank DO, Kimbell JS, Garcia GJ. A systematic review of patient-reported nasal obstruction scores: defining normative and symptomatic ranges in surgical patients. JAMA Facial Plast Surg. 2014;16(3):219–225.

Amiri et al., 2025 reported observational results of rhinophyma treatment using surgical cold blade technique or fractional ablative CO2 laser at the Zealand University Hospital from 2018 to 2023. Fifteen patients were included in this study, including 14 men and 1 woman. Eight patients were treated at the Department of Plastic Surgery and 7 at the Department of Dermatology. The mean age of the patients was 69.8 years for dermatological patients and 73.4 years for surgical patients. Amiri et al. used the rhinophyma severity index (RHISI) grading system to classify the severity, clinical progress and recurrence of rhinophyma.[6] The scale ranges from 0 to 6, where 0 indicates no rhinophyma and 6 is comparable to giant rhinophyma. Photographs were classified by experienced consultants, one from each department, and both were blinded to the treatment method. All patients completed a questionnaire about cosmetic satisfaction with treatment, quality of life (Qol) change and treatment recommendations to other patients. The questionnaire was on a scale of 1 to 5. A rating of 5 indicates excellent results, while a rating of 1 corresponds to poor or unsatisfactory outcomes. The data were gathered by phone after the end of follow-up in April 2024.

The baseline mean RHISI scores were 3.7 and 3.0 for patients treated using the cold blade technique and ablative fractional CO2 laser, respectively. The mean change in RHISI score was 2.1 for the cold blade technique and 1.7 for the ablative fractional CO2 laser. In general, the patients who underwent fractional ablative CO2 laser had a lower RHISI score pre-operatively, compared to the patients who received treatment with the cold blade technique. This is likely due to downstaging with isotretinoin or doxycycline before the procedure. Length of follow-up varied. Some patients had follow-up periods exceeding 3 years. Recurrence of rhinophyma was observed in 2 patients, one from each treatment category.

Overall, the patients in both groups reported good to excellent results based on the patient satisfaction scores with a calculated mean and standard deviation (SD) of 4.25+1.16 for the surgery group and 4.15+0.19 for the CO2-laser group. In total, 62% and 43% of the patients in the surgery group and CO2 laser group rated their results as excellent, respectively. One patient in the surgery group, who experienced rhinophyma recurrence, reported a moderate outcome and was uncertain whether he would recommend the treatment to other patients. In the CO2 laser group, 1 patient with mild rhinophyma at the baseline similarly expressed uncertainty towards recommending the treatment to others.

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.

Cosmetic surgery should not be billed to the Plan. When the patient requests the claim for cosmetic services be submitted on his/her behalf, the claims should be reported with diagnosis code Z41.1 Encounter for cosmetic surgery. The claim will be denied member liable.

[6] Wetzig et al., 2013 developed the Rhinophyma Severity Index (RHISI), which stratifies the disease based on degree of skin thickening, presence of lobules and fissures, and secondarily presence of prominent asymmetry, cysts, or vessels. Mild thickening: 1 point; Moderate skin thickening: 2 points; Severe thickening with formation of small lobules: 3 points; Lobules and fissures: 4 points; Giant Rhinophyma: 6 points, which is the maximum number of points.

Code	Description
HIV-Associated Lipodystrophy Syndrome Subcutaneous injection of filling material is covered with diagnosis of lipodystrophy associated with, or secondary to, HIV only. The following ICD-10-CM diagnoses are required on claims:. • B20 Human immunodeficiency virus [HIV] disease • E88.1 Lipodystrophy, not elsewhere classified For Medicare beneficiaries, Radiesse, 0.1ml (Q2026), Injection and Sculptra, 0.1ml (Q2028), must be billed with G0429. MassHealth only covers Sculptra (Q2028).	
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
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 (not payable for MassHealth ACO members)
Q2028	Injection, Sculptra 0.5 mg
Scar Revision (ICD-10-CM L90.5, L91.0), Scar Contracture Release (ICD-10-CM L90.5) And Keloid Excision (ICD-10-CM L73.0, L91.0, L94.0)	
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq. cm or less
11400	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq. cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm

11440	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13103	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13151	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, on the trunk, arms, and legs; first 100 sq cm or 1% of body area of infants and children
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits, first 100 sq cm or 1% of body area of infants and children
Removal of benign skin lesions Note: Medicare NCD 250.4 outlines coverage for the treatment of actinic keratosis (AK) diagnosis code L57.0.	
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (list separately in addition to code for primary procedure)
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm

11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
11400	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm

11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
17000	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
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
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	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
Blepharoplasty, Lower and Upper Eyelid	
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
Brow Ptosis Repair	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
Eyelid Ptosis Repair	
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

Correction of Lid Retraction	
67911	Correction of lid retraction
Correction of Lagophthalmos	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
Ectropion and Entropion Repair	
67914	Repair of ectropion; suture
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)
Rhytidectomy	
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
Excision of excessive skin and subcutaneous tissue	
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
Breast Reconstruction	
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
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander(s) without insertion of implant
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)
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)
19340	Insertion of breast implant on same day of mastectomy (ie immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19357	Tissue expander placement in breast reconstruction, including subsequent expansions(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, including closure of donor site
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous flap (TRAM), requiring separate microvascular
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous flap (TRAM)
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, readvancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19396	Preparation of moulage for custom breast implant
Mastectomy for gynecomastia	
19300	Mastectomy for gynecomastia
Correction of inverted nipples	
19355	Correction of inverted nipples
Chin surgery (mentoplasty/genioplasty)	
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)
Surgical repair of pectus excavatum or carinatum	
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
Surgical repair of Poland syndrome	
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk

15756	Free muscle or myocutaneous flap with microvascular anastomosis
20090	Bone graft, any donor area; minor or small (e.g., dowel or button)
20902	Bone graft, any donor area; major or large
Excision or surgical planing of nose for rhinophyma	
30120	Excision or surgical planning of skin or nose for rhinophyma
Rhinoplasty	
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
Repair of nasal vestibular stenosis or valve collapse	
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)
30469	Repair of nasal valve collapse with low energy, temperature-controlled (i.e., radiofrequency) subcutaneous/submucosal remodeling
Septoplasty	
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
Cleft lip and palate repair	
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1-stage procedure
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages
70420	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
42200	Palatoplasty for cleft palate, soft and/or hard palate only
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)
42215	Palatoplasty for cleft palate; major revision
42220	Palatoplasty for cleft palate; secondary lengthening procedure
42225	Palatoplasty for cleft palate; attachment pharyngeal flap
42226	Lengthening of palate, and pharyngeal flap

Canthoplasty/canthopexy	
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
67950	Canthoplasty (reconstruction of canthus)
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
Eyelid reconstruction	
67971	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, 1 stage or first stage
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
External ear reconstruction	
21230	Graft; rib cartilage, autogenous, to ear
21235	Graft, ear cartilage, autogenous, to nose or ear
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)
69320	Reconstruction external auditory canal for congenital atresia, single stage
Subcutaneous injection of filling material	
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 cc
Autologous Fat Grafting	
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)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
Hair transplantation	
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20sq cm or less
15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (List separately in addition to the code for the primary procedure)

15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
Abrasion and Dermabrasion	
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15786	Abrasion; single lesion (e.g., keratosis, scar)

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Policy history

Origination date:	06/2000
Review/Approval(s):	Benefit Review Committee: 08/1996, 10/1996, 02/1999, 07/2003 Technology Assessment Subcommittee: 06/2003, 06/01/2006, 04/08/2008 Technology Assessment Committee: 01/2004, 05/23/2006, 01/08/2008, 02/26/2008, 03/26/2013, 02/25/2015 (updated template, coverage for post-lumpectomy breast reconstruction, removed procedures that do not require Prior Authorization) 02/24/2016 (annual review no changes), 04/26/2017 (added clarification that medical records are required directly from providers who treat conservatively prior to requests for procedures), 03/28/2018 (annual review, no changes), 03/27/2019

(annual review, no updates), 06/15/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section), 04/23/2024 (annual review; updated Policy section to include Medicare regulatory and subregulatory guidance; updated Policy section to include MassHealth Guidelines for Medical Necessity Determination; added Summary of Evidence and Analysis of Evidence (Rationale for Determination); added Coding section; updated References), 6/24/2025 (annual review, adopted InterQual® Criteria for Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair, Rhinoplasty and Septoplasty, Reduction Mammoplasty, Mastectomy for Gynecomastia, Removal of Breast Implants, Panniculectomy, and Scar Revision, Scar Contracture Release, and Keloid Excision, added new sections for Medicare and MassHealth Variation, updated Evidence Summary to include new section for Excision or Surgical Planing of Rhinophyma, updated Coding and References).
Utilization Management Committee: 07/15/2025 (annual review, approved with adoption of InterQual® Criteria for Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair, Rhinoplasty and Septoplasty, Reduction Mammoplasty, Mastectomy for Gynecomastia, Removal of Breast Implants, Panniculectomy, and Scar Revision, Scar Contracture Release, and Keloid Excision).

Instructions for Use

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).

Fallon Health generally 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.

For plan members enrolled in NaviCare, Fallon Health first follows 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.

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.

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.