Mass General Brigham
Health Plan

Medical Policy
Reconstructive and Cosmetic Procedures

Policy Number: 051

	Commercial and Qualified Health Plans	MassHealth	Medicare Advantage
Authorization required	X	X	X
No Prior Authorization			

Overview
The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine medical appropriateness of procedures considered reconstructive and cosmetic in nature. The treating specialist must request prior authorization for reconstructive and cosmetic procedures.

Coverage Guidelines
Mass General Brigham Health Plan generally provides coverage when the surgery or procedure is reconstructive in nature, i.e., needed to improve the functioning of a body part, treat an associated medical complication, or is otherwise medically necessary, even if the surgery or procedure may also improve or change the appearance of a portion of the body. While this policy addresses many common procedures, it does not address all specific procedures that may be considered solely cosmetic in nature, and therefore excluded from coverage. Mass General Brigham Health Plan excludes coverage of cosmetic surgery and procedures that are performed primarily to improve or enhance a person's appearance as not medically necessary.

Mass General Brigham Health Plan covers medically necessary reconstructive surgery and procedures performed on structures of the body that are altered or damaged by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease when there is a physical functional impairment or ongoing medical complication that is expected to be improved upon with the requested procedure. Mass General Brigham Health Plan will also consider reconstructive/restorative procedures of the face to correct severe disfigurement under the circumstances described below.

Mass General Brigham Health Plan covers medically necessary reconstructive procedures when the following are met:

1. The medical condition or complication and the functional impairment is well documented by supportive testing and clinical notes (photos may be required, and when required may need to be emailed or mailed for visual clarity and quality); and
    a. If the procedure is listed in the criteria below, the specific criteria must also be met; or
    b. If the procedure is not listed above or in the criteria below, the medical necessity will be reviewed on an individual basis.
2. The requested procedure can be reasonably expected to resolve the medical condition or complication and functional impairment.

Note: For some conditions, a planned staged procedure may be medically appropriate, but for most conditions only the initial reconstructive procedure will be authorized unless a significant functional impairment or ongoing medical complication remains, and medical review criteria are met.

Members must meet the general coverage criteria and the criteria for any specific procedure below:

Eyelid(s)

- Blepharoplasty/Upper Blepharoptosis Repair for visual field impairment
- Upper or Lower Blepharoplasty for Non-Visual Field issues
- Brow Ptosis Repair

Nose

- Rhinoplasty
- Septoplasty

Facial

- See Oral and Maxillofacial Surgery and Procedures Medical Policy
- See Gender Affirmation Medical policy for applicable procedures

Chest

- See *Breast Surgeries Medical Policy* for Breast Surgeries and tattooing an areola
- Pectus excavatum (Prior authorization not required)
- Pectus carinatum (Prior authorization not required)
- Poland syndrome

Abdomen

- Panniculectomy

Skin

- Skin Redundancy: Removal on arms, legs, and buttocks
- Dermabrasion
- Scar Revision
- Skin lesion Removal
- Congenital Pigmented Nevi with possible increased malignancy potential
- Skin Tag Removal
- Hemangioma Destruction
- Port Wine Stain Treatment by Laser
- Hair Removal

Appendages

- Supernumerary Digit Removal

Veins

- Varicose Vein Treatment

Trauma to the Face

Mass General Brigham Health Plan covers medically necessary restorative procedure for the face when all of the following are met:

1. The circumstances of the accidental trauma and the degree of injury are well documented by supportive testing and clinical notes. (Photos may be required, and when required, may need to be emailed or mailed for visual clarity and quality).
2. The procedure must be requested and performed within 18 months of the accidental injury; or
    a. For children who have not reached full maturity (i.e., age 16 or less), the medical record must document that a delay greater than 18 months for performing the initial restorative procedure was required in order for growth to be complete; or
    b. For any other delay greater than 18 months, the medical record must document that the postponement of the initial restorative procedure was required in order for optimal reconstruction, healing, and remodeling.
3. The requested procedure can be reasonably expected to have a successful outcome.

Note: Only the initial restorative procedure will be authorized, unless a significant functional impairment or ongoing medical complication remains, and medical review criteria for a reconstructive procedure are met.

Exclusions
See General Exclusions

Specific Criteria for Selected Reconstructed Procedures

Eyes
Blepharoplasty/Upper Blepharoptosis Repair for visual field impairment
Medical necessity for Blepharoplasty is determined through InterQual® criteria. To access the criteria, log in to Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions
See General Exclusions

Upper or Lower Blepharoplasty for Non-Visual Field issues
Medical necessity for upper or lower blepharoplasty for non-visual field issues is determined through InterQual® criteria. To access the criteria, log in to Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions
See General Exclusions

Brow Ptosis Repair
Medical necessity for brow ptosis repair is determined through InterQual® criteria. To access the criteria, log in to Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Ears
Otoplasty
Otoplasty is medically necessary for congenital absence of the ear (anotia) or severe (grade III) microtia. Otoplasty is considered cosmetic for all other indications.

Nose
Rhinoplasty
Medical necessity for rhinoplasty is determined through InterQual® criteria, which Mass General Brigham Health Plans has customized by including additional procedure codes. To access the customized criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions
See General Exclusions

Septoplasty
Medical necessity for septoplasty is determined through InterQual® criteria. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions
See General Exclusions

Chest

Pectus Excavatum surgical repair (Prior authorization not required)

Medical necessity for pectus excavatum repair is determined through InterQual® criteria. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Pectus Carinatum surgical repair (Prior authorization not required)

Surgical repair is generally not medically necessary, as the condition is asymptomatic in the vast majority of people. Mass General Brigham Health Plan covers medically necessary surgical repair when:

1. The member has a severe chest wall deformity causing (or at risk for causing) cardiovascular or respiratory compromise; and
2. The medical record clearly documents the degree of deformity and its direct relationship to the symptoms including supportive cardiopulmonary testing such as pulmonary function testing; and
3. The member has completed bone growth, generally when greater than or equal to 15 years of age.

Pectus Carinatum bracing

Bracing for is generally not medically necessary, as the condition is asymptomatic in the vast majority of people. Mass General Brigham Health Plan covers medically necessary bracing when:

1. The member has a severe chest wall deformity causing (or at risk for causing) cardiovascular or respiratory compromise; and
2. The medical record clearly documents the degree of deformity and its direct relationship to the symptoms including supportive cardiopulmonary testing such as pulmonary function testing; and
3. There is documentation that the member understands and is willing to adhere to the recommended bracing protocol (number of hours and length of use); and
4. The member has been evaluated for scoliosis by physical exam or imaging, and has not been found to have moderate or severe scoliosis (Cobb angle >25 degrees); and
5. The member is a child whose costal cartilage has been assessed as compliant.

Exclusions

1. Male pectoral augmentation for the purpose of enhancing the chest region unrelated to the surgical repair of the chest wall as covered in this policy or the Breast Surgeries policy.
2. See General Exclusions

Poland Syndrome

See Breast Surgeries Clinical Coverage Criteria for breast reconstruction for members with Poland Syndrome. Mass General Brigham Health Plan covers medically necessary surgical repair of associated chest wall deformity when one of the following are met:

1. The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise; or
2. The medical record documents chest wall defects in which the chest viscera are exposed and susceptible.

Exclusions

1. Costal aplasia or hypoplasia without physical functional impairment.

Abdomen

Panniculectomy

Medical necessity for panniculectomy of the abdomen is determined through InterQual® criteria. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu. Photo documentation is required.

Exclusions

1. Abdominoplasty.
2. See General Exclusions

Labiaplasty

Labiaplasty may be authorized for a diagnosis of labial hypertrophy in members at least 18 years of age when there is documentation of:

1. Functional deficit that interferes with activities of daily living;
2. Recurrent rashes/ulcers in the affected areas that have not responded to conservative treatment (e.g. topical medications);
3. Dyspareunia.

Labiaplasty for gender affirming surgery – see Gender Affirmation Procedures Medical Policy.

Exclusions

1. Labiaplasty performed solely for cosmetic purposes.

Skin

Skin Redundancy: removal on arms, legs, and buttocks

See panniculectomy above for removal of redundant skin of abdomen. See *Breast Surgeries Medical Policy* for breast reduction criteria.

Mass General Brigham Health Plan covers medically necessary removal of redundant skin when criteria 1 and 2 are met:

1. The redundant skin is the result of weight loss of at least 75 pounds that has been stable for at least 6 months, and if the weight loss occurs as a result of bariatric surgery, the member must be at least 12 months post bariatric surgery.
2. There is written and photographic supporting documentation that the occlusive redundant skin directly causes one of the following:
    a. Symptomatic intertriginous ulcerations or macerations that are unresponsive to good personal hygiene and well documented optimal physician-supervised local treatment and that continually persist for a period of at least six months despite this care and treatment. Required lateral and frontal photos must demonstrate a significantly redundant and occlusive skin fold, and additional photos must document the presence of intertriginous skin ulceration and maceration; or
    b. Recurrent bacterial skin infections (at least 2 in a 12-month period) directly related to the redundant skin, which required systemic antibiotics. Required lateral and frontal photos must demonstrate a significantly redundant and occlusive skin folds.

Note: Liposuction is often an integral part the surgical removal of excessive skin this is not separately reimbursed.

Exclusions

See General Exclusions

Dermabrasion

Mass General Brigham Health Plan medical necessity criteria for dermabrasion is determined through a custom subset accessible through InterQual®. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu, or see below:

1. To remove superficial basal cell carcinomas and pre-cancerous actinic keratoses when conventional methods of treatment (cryotherapy, curettage, excision, and 5-FU) are impractical due to the number and distribution of the lesions, or
2. For restoration after previous medically necessary surgery.

Exclusions

1. Dermabrasion or other cosmetic dermatologic procedures performed for the removal of acne, acne scars, wrinkles, or uneven pigmentation is not considered medically necessary and is not a covered benefit.
2. See General Exclusions

Scar Revision (including Keloid Revision)

Medical necessity for scar revision is determined through InterQual® criteria. For fractional laser ablation for burns and traumatic scars, use the customized InterQual Scar Revision criteria which includes additional codes. Photo documentation may be required. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Skin Lesion Removal

Mass General Brigham Health Plan covers medically necessary skin lesion removal in the following situations:

1. Any lesion clinically suspicious for malignancy;
2. Any presumably benign lesion that grows or enlarges, begins to bleed, or ulcerate or that is exposed to frequent irritation; or
3. Nevi when the rationale is to reduce the risk of malignant transformation.

Notes: Photo documentation may be required.
The following *does not require prior authorization:*

- Tangential biopsy of skin, single lesion; each additional lesion
- Punch biopsy of skin, single lesion; each additional lesion
- Incisional biopsy of skin, single lesion; each additional lesion
- Excisions and simple closure, benign lesions
- Excision, malignant lesions
- Injection into skin
- Destruction of benign lesion(s) other than skin tags or cutaneous vascular proliferative lesions

Exclusions

See General Exclusions

Skin Tag Removal

Note: Skin tag removal *does not require prior authorization.*

Mass General Brigham Health Plan covers medically necessary removal of a skin tag. The medical record should clearly document the size, location, and characteristics of the skin tag and one or more of the following conditions is present:

1. Chronic, recurrent, or persistent bleeding, intense itching, and/or pain.
2. Physical evidence of inflammation, e.g.; purulence (containing pus), oozing, edema, erythema (redness).
3. There is a clinical uncertainty as to the likely diagnosis, particularly where malignancy (cancer) is a realistic consideration based on the appearance or growth.
4. The skin tag is in an anatomical region subject to recurrent physical trauma and that such trauma has, in fact, occurred.

5. The skin tag obstructs an orifice or clinically restricts vision.
6. A preauricular skin tag containing both skin and cartilage

Hemangioma Destruction
Mass General Brigham Health Plan medical necessity criteria for hemangioma destruction is determined through a custom subset called "Hemangioma Destruction and Port Wine State Treatment" accessible through InterQual®. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu, or see below:
The medical record clearly documents the size, location, and characteristics of the hemangioma and at least **one** of the following:

1. The hemangioma is on the face, neck, or ears; or
2. The hemangioma is causing a functional impairment of vital structures (e.g., impaired vision or astigmatism due to eyelid or periorbital hemangiomas; auditory impairment and secondary speech delay due to hemangiomas in the ear); or
3. The hemangioma has recurrent bleeding, ulceration, or infection; or
4. The hemangioma is pedunculated; or
5. The hemangioma is associated with Kasabach-Merritt syndrome.

Note: photo documentation may be required.

Exclusions

1. Treatment (i.e., laser) of congenital capillary hemangiomas that are naturally resolving and in the absence of interference with a vital structure (eye, airway) or with documented recurrent infection or significant bleeding requiring medical intervention.
2. See General Exclusions

Port Wine Stain Treatment by Laser
Mass General Brigham Health Plan medical necessity criteria for port wine stain treatment by laser is determined through a custom subset called "Hemangioma Destruction and Port Wine State Treatment" accessible through InterQual®. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu, or see below:
The medical record clearly documents the size, location, and characteristics of the port wine stain, and at least one of the following:

1. The port wine stain is on the face and neck; or
2. The port wine stain has recurrent bleeding, ulceration, or infection.

Note: photo documentation may be required.

Exclusions
See General Exclusions

Hair Removal
Mass General Brigham Health Plan covers hair removal (with laser or electrolysis) by a treating licensed provider or board-certified dermatologist, when the member meets one of the following criteria**:**

1. Treatment for recurrent hair follicle infections, recurrent infected cysts, or when it is being done to prevent recurrence or infections after surgical treatment of pilonidal sinus disease.
2. It is being done as part of treatment for gender incongruence (dysphoria). Please see the Mass General Brigham Health Plan's Gender Affirming Procedures Policy for further detail and exclusions.

Appendages

Supernumerary Digit Removal

Mass General Brigham Health Plan covers medically necessary removal of supernumerary digits for members up to the age of 19 years.

Exclusions

1. The member is over 19 years of age.
2. See General Exclusions

Veins

Varicose Vein Ligation and Stripping, Ablation, Ambulatory Phlebectomy, Sclerotherapy

Medical necessity for varicose vein treatment is determined through InterQual® criteria which Mass General Brigham Health Plan has customized by including additional codes. The name of this customized subset is "Ablation, Endovenous, Varicose Vein – (Commercial) (Custom) – MGB." To access the customized criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu or see below:

Exclusions

See General Exclusions

General Exclusions

Mass General Brigham Health Plan does not provide coverage for reconstructive procedures for conditions that do not meet the criteria noted above, including but not limited to:

1. Coverage of cosmetic surgery and procedures and non-surgical **cosmetic dermatology** procedures that are solely to enhance a patient's appearance in the absence of any signs or symptoms of functional abnormalities; and/or associated medical complication is considered cosmetic and is not a covered benefit, unless specifically noted otherwise in this coverage criteria.
2. Any procedure where the primary purpose is to enhance aesthetics, including but not limited to:
    a. Hair transplantation
    b. Liposuction
    c. Facial implants
    d. Calf implants
    e. Skin tightening
    f. Chemical peels
    g. Laser skin resurfacing
3. Hair removal aside from those conditions listed under hair removal above.

Note: For procedures involving Gender Reassignment please refer to the Gender Affirming Procedures policy.

4. Thyroid cartilage shaving surgeries or procedures performed primarily for psychological or emotional reasons.
5. Scalp cooling caps to prevent hair loss.

Related Policies

- Breast Surgeries Medical Policy

- Oral and Maxillofacial Surgery and Procedures Medical Policy
- Phototherapy and Photochemotherapy for Dermatologic Conditions Medical Policy
- Dermatology Provider Payment Guidelines
- HIV-Associated Lipodystrophy Syndrome Medical Policy
- Gender Affirming Procedures Medical Policy
- Medicare Advantage Administration Guidelines Medical Policy

Medicare Variation

Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for coverage determinations**.** At the time of Mass General Brigham Health Plan's most recent policy review, Medicare includes the following:

- NCD: Treatment of Actinic Keratosis (250.4).
- LCD: Varicose Veins of the Lower Extremity, Treatment of (L33575).
- LCD: Blepharoplasty, Blepharoptosis and Brow Lift (L34528).
- Local Coverage Article: Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908).
- Local Coverage Article: Blepharoplasty - Medical Policy Article (A52837).
- CMS Medicare Benefit Policy Manual Chapter 16- General Exclusions from Coverage.

MassHealth Variation

Mass General Brigham Health Plan uses guidance from MassHealth for coverage determinations for its Mass General Brigham Medicaid ACO members. **At the time of Mass General Brigham Health Plan's most recent policy review, MassHealth has the following medical necessity guidelines:**

- **Blepharoplasty, Upper Eyelid Ptosis, and Brow Ptosis Surgery**
- **Rhinoplasty and Septoplasty**
- **Excision of Excess Skin and Subcutaneous Tissue**
- **Hair Removal**
- **Varicose Veins**

Codes

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

The following list of codes applies to commercial and MassHealth plans only.

Authorized CPT/HCPCS Codes	Code Description
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead (Not covered for MassHealth Plans)

15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) (Not covered for MassHealth Plans)
15826	Rhytidectomy; glabellar frown lines (Not covered for MassHealth Plans)
15828	Rhytidectomy; cheek, chin, and neck (Not covered for MassHealth Plans)
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap (Not covered for MassHealth Plans)
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
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
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21280	Medial canthopexy (separate procedure)

21282	Lateral canthopexy
30120	Excision or surgical planing of skin of nose for rhinophyma
30220	Insertion, nasal septal prosthesis (button)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	Repair nasal septal perforations
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated (Not Reimbursed for MassHealth Plans)
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) (Not Reimbursed for MassHealth Plans)
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37718	Ligation, division, and stripping, short saphenous vein
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg
67715	Canthotomy (separate procedure)
67830	Correction of trichiasis; incision of lid margin
67835	Correction of trichiasis; incision of lid margin, with free mucous membrane graft
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)

67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67914	Repair of ectropion; suture
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage
67974	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, 1 stage or first stage
67975	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage
69300	Otoplasty, protruding ear, with or without size reduction
L1320	Thoracic pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated

Effective

March 2025: Annual review.

- Added references to InterQual subsets and, where necessary, added customized InterQual criteria.
- Added criteria for bracing for Pectus Carinatum.
- Added code for Pectus Carinatum brace.
- Updated list of skin biopsies not requiring PA.
- Removed liposuction for lipedema exclusion.
- Added exclusion regarding scalp cooling to prevent hair loss.
- References updated.

October 2024: Off-cycle review. Added MassHealth Variation. Removed references to MassHealth elsewhere in the policy. Updated codes.

January 2024: Annual review. Added criteria for Otoplasty. Added Bracing to the Pectus Carinatum criteria. Updated codes.

February 2023: Annual review. The following changes were made:

Page 1: Added Medicare Advantage to table.

Page 1: Under Coverage Guidelines;

- Removed “AllWays Health Partners reserves the right to deny coverage for any procedures that are considered cosmetic and not medically necessary.”
- Clarified coverage by adding “that are altered or damaged”.

- Reformatted section for clarity purposes. Criteria unchanged.

Page 2: Added Gender Affirmation Medical Policy statement under Facial procedure
Page 3:

- Added “Prior Authorization is not required” next to both Pectus Excavatum and Carinatum subheadings.
- Edited Pectus Carinatum criteria for clarity purposes. Criteria unchanged.

Page 4: Added Labiaplasty criteria.
Page 5: Under Scar Revision criteria, added fractional laser ablation statement.
Page 7: Under Hair Removal criteria, added term “incongruence”.
Page 8: Added Medicare Variation language. Also added statement regarding code list.
June 2022: Off-cycle review. Added hair removal to skin criteria on page 2. Added hair removal criteria to page 8. Edited hair removal exclusion on page 9.
January 2022: Annual review. Edited Hair Removal exclusion for clarity. References updated.
April 2021: Off-cycle review. Under General Exclusions: added “Hair removal for the treatment of recurrent pilonidal cysts”.
January 2021: Annual review. Under Hemangioma Destruction section, added hemangioma is on the face, neck or ears. Code update. 30465 Added.
March 2020: Off-cycle review. Added Liposuction for lipedema as a general exclusion. References updated.
June 2019: Off-cycle review. Added MassHealth language for Varicose Veins. Adopted MassHealth guidelines for MassHealth members. Updated References section.
January 2019: Annual review. Added CPT codes. Updated references.
December 2017: Annual review. Updated time requirement from 12 months to 18 months, under trauma to the face.
May 2017: Changes reflect the addition of InterQual® varicose veins treatment criteria.
February 2017: Changes reflect the addition of InterQual® eye, nose, chest, abdomen, and scar revision criteria.
October 2016: Annual review.
October 2015: Annual review and updates included expanded list of cosmetic surgery and procedures and non-surgical cosmetic dermatology procedures for the primary purpose of enhancing aesthetics, and clarification of varicose vein criteria References updated.
October 2014: Annual review. Updates included reformatted and clarified criteria. Added general criteria, criteria for the face, skin redundancy removal to arms legs and buttocks, and new criteria for varicose veins. Added procedures under coverage guidelines.
March 2013: Annual review.
February 2012: Annual review.
February 2011: Annual review.
January 2010: Annual review.
January 2009: Annual review.
January 2008: Annual review.
January 2007: Annual review.
December 2006: Annual review.
November 2005: Effective Date.

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