Clinical Review Criteria
Restorative and Cosmetic Procedures

- Abdominoplasty
- Panniculectomy

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Criteria
For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
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<tbody>
<tr>
<td>CMS Coverage Manuals</td>
<td>Medicare Benefit Policy Manual Chapter 16 - General Exclusions from Coverage</td>
</tr>
<tr>
<td>National Coverage Determinations (NCD)</td>
<td>None</td>
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</tbody>
</table>
| Local Coverage Determinations (LCD) | Plastic Surgery (L37020)  
Non-Covered Services (L35008). |
| Local Coverage Article        | Cosmetic vs. Reconstructive Surgery (A52729)  
Medicare retired Article for Cosmetic vs. Reconstructive Surgery (A52729). These services still need to meet medical necessity as outlined in the LCA and will require review. LCAs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Decision (NCD), a coverage provision in a CMS interpretative manual or an article. Most LCAs are not retired because they are incorrect. Therefore, continue to use LCA A52729 for determining medical necessity. |

For Non-Medicare Members

Cosmetic Surgery is performed to reshape normal structures of the body in order to improve appearance in the absence of a specific functional improvement. Surgery performed to improve on "natural" appearance or performed purely for the purpose of enhancing one's normal appearance is not considered reasonable and necessary.

Reconstructive Surgery is performed to restore bodily function or to correct a deformity resulting from disease, injury, trauma, birth defects, congenital anomalies, infections, burns or previous medical treatment, such as surgery or radiation therapy. The primary goal is to restore function. Reconstructive surgery is reasonable and necessary to improve the functioning of a malformed body part.

I. Abdominoplasty
   1. Abdominoplasties are not covered as they are considered cosmetic.
      i.e. Repair of diastasis recti

   Excision of excessive skin (thigh, leg, hip, buttock, or upper arm): is covered when ALL of the following criteria are met:
   1. Documentation in the medical record of the presence of infections that:
a. Have been refractory to systemic treatment for bacterial infection control with oral or parenteral antibiotics.

b. Have required at least two serial office visits for the same occurrence.
   i. If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, procedure should not be performed until at least 18 months after bariatric surgery.
   ii. Excess skin is impairing normal function

Panniculectomy is covered when **ALL of the following** criteria are met:

1. Must meet criteria for excision of excessive skin (above) – (e.g. infection refractory to systemic treatment for bacterial infection)
2. Panniculus hangs below the level of the pubis (documented by photographs)
3. Interferes with activities of daily living
4. Not covered when performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy are met separately
5. Not covered to minimize the risk of hernia formation or recurrence

See individual links below for the following potentially cosmetic procedures:
- Blepharoplasty
- Dermatological Procedures
- Poly-L-Lactic Acid Injection (Sculptura)
- Reduction Mammaplasty
- Rhinoplasty
- Breast Reconstruction
- Skin Lesions
- Vein Procedures

The following are considered cosmetic in nature and non-covered under members contact:
- Cervicoplasty (“neck lift”)
- Collagen injection
- Hair Transplant
- Canthoplasty (“outer eyelid lift surgery”)

If requesting this service, please send the following documentation to support medical necessity:
- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, KPWA will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

**Background**

Kaiser Permanente coverage contracts exclude cosmetic procedures. However, some procedures may be medically necessary when certain clinical criteria have been met. This document has been created to provide guidance to physician’s reviewers when reviewer requests to cover potentially cosmetic services.

**Evidence and Source Documents**

**Member contract**

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<thead>
<tr>
<th>Date Created</th>
<th>Dates Reviewed</th>
<th>Date Last Revised</th>
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MDCRPC Medical Director Clinical Review and Policy Committee
### MPC Medical Policy Committee

<table>
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<tr>
<th>Revision History</th>
<th>Description</th>
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<tbody>
<tr>
<td>11/01/2015</td>
<td>Changed Medicare links</td>
</tr>
<tr>
<td>05/03/2016</td>
<td>Added definitions for Cosmetic vs. Reconstructive Surgery. Added a list of non-covered cosmetic services</td>
</tr>
<tr>
<td>12/19/2017</td>
<td>Added LCD 37020</td>
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### Codes

- **Abdominoplasty**: 15847
- **Panniculectomy**: 15830
- **Excision of Excess Skin**: 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839

**Review for Cosmetic vs. Reconstructive**

- **Cervicoplasty**: 15819
- **Collagen injection**: 11950, 11951, 11952, 11954
- **Hair Transplant**: 15775, 15776
- **Canthoplasty**: 67950
- **Otoplasty**: 69300
- **Tissue Expanders**: 11960, 11970, 11971
- **Wrinkle Removers**: 15824, 15825, 15826, 15828, 15829
- **Lipectomy**: 15876, 15877, 15878, 15879