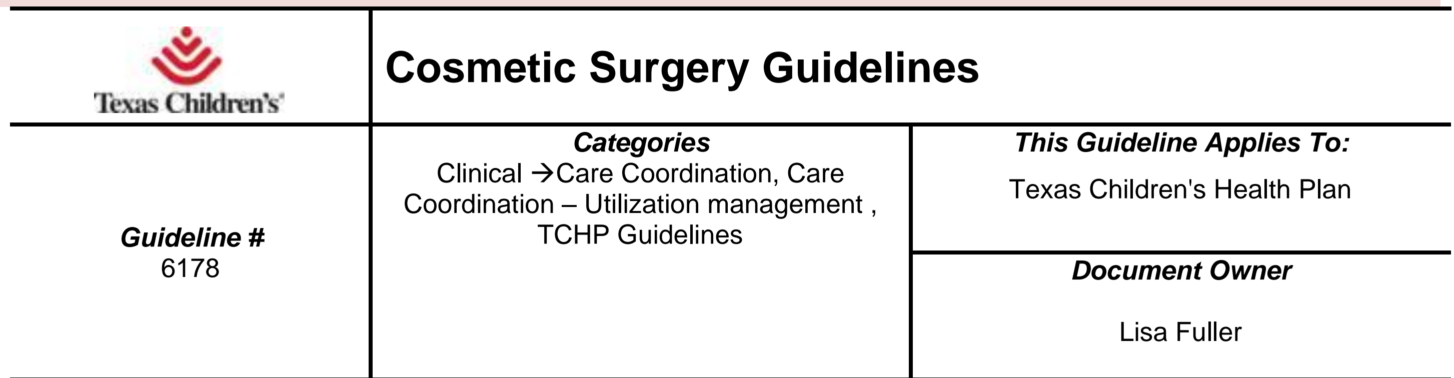

Texas Children's	Cosmetic Surgery Guidelines	
Guideline # 6178	***Categories*** Clinical →Care Coordination, Care Coordination – Utilization management , TCHP Guidelines	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Lisa Fuller

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all Cosmetic Surgery Procedures.

DEFINITIONS:

Abdominoplasty: A procedure involving the removal of excess abdominal skin and fat between the pubis and the umbilicus, sometimes higher, with or without tightening lax anterior abdominal wall muscles and with or without repositioning or reconstruction of the navel.

Panniculectomy: A procedure designed to remove fatty tissue and excess skin (panniculus) from the lower to middle portions of the abdomen.

GUIDELINE

1. All requests for prior authorization for Cosmetic surgery procedures are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.
2. The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports the cosmetic surgery procedure as an eligible service.
3. To request prior authorization for cosmetic surgery, the requesting provider must supply:
   3.1. documentation supporting the medical necessity of the procedure requested
   3.2. Identify the location or facility where the services will be provided
4. TCHP covers medically necessary cosmetic surgery or reconstructive procedures when the following are met:

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4.1. The medical condition or complication and the functional impairment is well documented by supportive testing and clinical notes; **AND**

4.1.1. If the procedure is listed in the criteria below, the specific criteria must also be met; **Or**

4.1.2. If the procedure is not listed in the criteria below, medical necessity will be reviewed on an individual basis.

4.2. The requested procedure can be reasonably expected to resolve the medical condition or complication and functional impairment.

4.3. The requested procedure cannot have the primary purpose of: weight loss for its own sake, cosmetic purposes, reasons of psychological dissatisfaction with personal body image or for the member's or provider's convenience or preference.

5. Establishing Medical Necessity for Cosmetic Surgery Procedures:

5.1. Face

5.1.1. Collagen injections that are used for cosmetic surgery are not considered medically necessary and are not a benefit of Texas Medicaid.

5.1.2 TCHP covers medically necessary restorative procedure for the face when the all of the following are met:

5.1.2.1 The circumstances of the accidental trauma and the degree of injury are well documented by supportive testing and clinical notes.

5.1.2.2 The procedure must be requested and performed within 12 months of the accidental injury; **Or**

5.1.2.3 For children who have not reached full maturity (i.e. age 16 or less), the medical record must document that a delay greater than 12 months for performing the initial restorative procedure was required in order for growth to be complete; **Or**

5.1.2.4 For any other delay greater than 12 months, the medical record must document that the postponement of the initial restorative procedure was required in order for optimal reconstruction, healing, and remodeling.

5.1.2.5 The requested procedure can be reasonably expected to have a successful outcome.

5.2 Eyes

5.2.1 Blepharoplasty is considered medically necessary to relieve obstruction of central vision when **ALL** of the following criteria are met

5.2.1.1 Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; **AND**

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5.2.1.2 There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue. This must be confirmed by photographs taken within the last 12 months from the front and side (or sides) on which operation planned with the camera at eye level and the individual looking straight ahead (primary gaze); **AND**

5.2.1.3 Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal; **AND**

5.2.1.4 Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

5.2.2 Blepharoptosis repair

5.2.2.1 In children, blepharoptosis repair is considered medically necessary

- When ptosis interferes with field of vision (visual field testing not required, but provider should submit a photograph of the patient documenting ptosis); **AND**
- Child has abnormal head posture (e.g., head tilt or turn, chin up or chin down), amblyopia or strabismus.

5.2.2.2 In adults, blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when **ALL** of the following criteria are met:

- Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; **AND**
- Photographs taken with the camera at eye level and the individual looking straight ahead, document the abnormal lid position (photos should be submitted for review); **AND**
- Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal, or c) the margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm; **AND**
- Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

5.2.3 Brow lift (i.e., repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when **ALL** of the following criteria are met:

5.2.3.1 Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field

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related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; **AND**

5.2.3.2 Photographs show the eyebrow below the supraorbital rim.

5.3 Nose

5.3.1 Rhinoplasty**:** TCHP covers medically necessary rhinoplasty when performed to correct:

5.3.1.1 Obstructive symptoms. All of the following criteria must be met:

- The member has well documented moderate to severe symptomatic airway compromise.
- There are no other identifiable causes of obstructive symptoms (e.g., polyps, nasal edema, enlarged turbinates, septal defect).
- A reasonable trial of appropriate conservative treatment has failed (e.g. 4-week trial of nasal steroids for polyps or allergic nasal edema).
- Septoplasty and/or turbinectomy is not to be expected to resolve the obstructive symptoms.
- When supportive testing has been performed (e.g. X-rays or CT report of a fracture) this documentation must be submitted.

5.3.1.2 Nasal deformity consequent to the treatment of congenital cleft lip and/or palate or for other congenital anomalies or tumors such as nasal dermoid, nasal glioma, or encephalocele involving the nose.

5.3.1.3 Deformity of nasal bones resulting from trauma that occurred within the past 12 months when *General Coverage Criteria* for facial restoration in 5.1 are met.

5.3.2 Septoplasty: TCHP covers medically necessary septoplasty for:

5.3.2.1 Obstructive symptoms when all of the following are met:

- Disease, trauma, or tumor-ablative surgery causes a moderate to severe septal deviation, or a septal perforation.
- The deviated, perforated, or deformed septum directly causes: symptomatic, moderate (≥ 50%) to severe (≥ 75%) degree of airway obstruction, recurrent nose bleeds, recurrent sinusitis, or intolerance to CPAP.
- There are no other identifiable causes of the symptoms or obstruction (e.g., polyps, nasal edema, or enlarged turbinates).
- When the degree of obstruction is less than 75%, the member must have failed a reasonable trial of appropriate conservative treatment (e.g., a 4-week trial of nasal steroids).

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5.3.2.2 The treatment of headache originating from septal spur. (Septal spur headache may be diagnosed when pain is relieved temporarily by topical anesthetics applied to the septal impaction.)

5.3.2.3 Septal deformity consequent to the treatment of congenital cleft lip and/or palate (see Oral and Maxillofacial Surgery Criteria) or for other congenital anomalies or tumors such as nasal dermoid, nasal glioma, **Or** encephalocele involving the septum.

5.3.2.4 Deformity of septum resulting from trauma that occurred within the past 12 months when *General Coverage Criteria* for facial restoration in 5.1 are met.

5.4 Chest

5.4.1 Pectus Excavatum: TCHP covers medically necessary surgical repair of pectus excavatum when:

5.4.1.1 The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise;

5.4.1.2 The medical record clearly documents the degree of deformity and its direct relationship to the symptoms; **AND**

5.4.1.3 The Haller Index (transverse chest to narrowest anteroposterior diameter) is at least 3.25.

5.4.1.4 Note: Ideally the surgical repair should take place when the member has completed bone growth, generally when greater than or equal to 15 years of age.

5.4.2 Pectus Carinatum: Surgical repair is generally not medically necessary, as the condition is asymptomatic in the vast majority of people. TCHP covers medically necessary surgical repair when:

5.4.2.1 The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise;

5.4.2.2 The medical record clearly documents the degree of deformity (via Haller index or other) and its direct relationship to the symptoms including supportive cardiopulmonary testing such as pulmonary function testing; and;

5.4.2.3 The member has completed bone growth, generally when greater than or equal to 15 years of age.

5.4.3 Breast Procedures are covered in the Guideline for Therapeutic and Reconstructive Breast Procedures.

5.5 Abdomen

5.5.1 Panniculectomy: The American Society of Plastic Surgery considers panniculectomy reconstructive because it is usually performed to correct a

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functional impairment. It does not include muscle plication, naval reconstruction or flap elevation. It may be performed at the same time as an abdominoplasty. Panniculectomy is subject to medical necessity criteria.

5.5.2 TCHP covers medically necessary panniculectomy for members who meet all of the following criteria (1-4):

5.5.2.1 The panniculus hangs below the level of the pubis

5.5.2.2 **ONE** of the following:

- There are documented recurrent or chronic rashes, infections, cellulitis, or non-healing ulcers, that do not respond to conventional treatment (for example, dressing changes; topical, oral or systemic antibiotics, corticosteroids or antifungals) for a period of 3 months; **Or**
- There is documented difficulty with ambulation and interference with the activities of daily living;

5.5.2.3 Symptoms or functional impairment persists despite significant* weight loss which has been stable for at least 3 months or well-documented attempts at weight loss (medically supervised diet or bariatric surgery) have been unsuccessful;

- Significant weight loss varies based on the individual clinical circumstances and may be documented when the individual:
  - Reaches a body mass index (BMI) less than or equal to 30 kg/m2; **Or**
  - Has documented at least a 100-pound weight loss; **Or**
  - Has achieved a weight loss which is 40% or greater of the excess body weight that was present prior to the individual's weight loss program or surgical intervention.

5.5.2.4 If the individual has had bariatric surgery, he/she is at least 18 months' post-operative or has documented stable weight for at least 3 months.

5.5.3 Abdominoplasty: TCHP covers medically necessary abdominoplasty for members who have any of the following conditions:

5.5.3.1 Prune belly

5.5.3.2 Diastasis recti in the presence of a true midline hernia (ventral or umbilical)

5.6 Skin

5.6.1 Skin redundancy: Removal of redundant skin from arms, legs, and buttocks is considered medically necessary when ALL the following criteria are met:

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5.6.1.1 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 occurred as a result of bariatric surgery, the member must be at least 12 months post bariatric surgery.

5.6.1.2 There is supporting documentation that the occlusive redundant skin directly causes **ONE** of the following:

- 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.
- Recurrent bacterial skin infections (at least 2 in a 12-month period) directly related to the redundant skin, which required systemic antibiotics.

5.6.2 Treatment of Keloids or Scar Revision is considered medically necessary when **ALL** of the following criteria are met:

5.6.2.1 There is documented evidence of significant physical impairment related to the keloid or scar such as:

- The scar causes a physical functional impairment (e.g., interferes with movement of a joint);
- The scar causes symptoms of intense pain, burning or itching that cannot be effectively treated with local or systemic medication (e.g. analgesics, corticosteroids or antibiotics);
- The scar has recurring breakdown and infection that is refractory to local medical treatment; or
- The scar is the result of severe facial disfigurement, which has necessitated medically necessary facial surgery occurring within the last year (excluding scar revisions for the treatment of acne or acne scars);

5.6.2.2 The treatment can be reasonably expected to improve the physical functional impairment.

5.6.3 Skin Tag Removal: TCHP 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:

- Chronic, recurrent, or persistent bleeding, intense itching, and/or pain.
- Physical evidence of inflammation, e.g.; purulence (containing pus), oozing, edema, erythema (redness).
- There is a clinical uncertainty as to the likely diagnosis, particularly where malignancy (cancer) is a realistic consideration based on the appearance or growth.

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- The skin tag is in an anatomical region subject to recurrent physical trauma and that such trauma has, in fact, occurred.
- The skin tag obstructs an orifice or clinically restricts vision.
- A preauricular skin tag containing both skin and cartilage

5.6.4 Hemangioma destruction: TCHP covers medically necessary hemangioma destruction when the medical record clearly documents the size, location, and characteristics of the hemangioma and **ONE** of the following:

- 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);
- The hemangioma has recurrent bleeding, ulceration, or infection;
- The hemangioma is pedunculated;
- The hemangioma is associated with Kasabach-Merritt syndrome.

5.6.5 Port Wine Stain Treatment by Laser: TCHP covers medically necessary port wine stain treatment by laser when the medical record clearly documents the size, location and characteristics of the port wine stain, and **ONE** of the following:

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

5.6.6 Supernumerary Digit Removal: TCHP covers medically necessary removal of supernumerary digits for members up to the age of 19 years.

5.7 Veins

5.7.1 Varicose Vein Ligation and Stripping, Ablation, Ambulatory Phlebectomy, Sclerotherapy: TCHP covers medically necessary varicose vein treatment when the varicosities result in one of the clinical symptoms below and the criteria to treat the specific vein are met:

5.7.1.1 Clinical symptoms

- Intractable ulceration secondary to venous stasis;
- More than one episode of minor hemorrhage from a ruptured superficial varicosity;
- A single significant hemorrhage from a ruptured superficial varicosity, especially if transfusion of blood is required;
- Significant lipodermatosclerosis related to venous insufficiency;
- Recurrent superficial thrombophlebitis or persistent and symptomatic superficial thrombophlebitis unresponsive to 6 weeks of conservative

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treatment (i.e., appropriate length, prescription 20-30 mm pressure gradient compression stockings); or

- Severe and persistent pain or swelling interfering with activities of daily living or requiring chronic analgesic medication with an unsuccessful trial of 6 weeks of conservative management (i.e., appropriate length, prescription 20-30 mm pressure gradient compression stockings).

5.7.1.2 Superficial Axial Varicose Veins: Great Saphenous Vein (GSV), Small Saphenous Vein (SSV), Anterior Accessory Great Saphenous Vein (AAGSV)

- When member meets symptoms criteria above (5.7.2.1);
- There is a duplex ultrasound of the deep and superficial venous system performed while the member is standing that documents a varicose vein with at least reflux >1 second and a venous diameter of at least ≥ 3 mm in its full length or a large proportion of its length such that it is likely to be directly causing the member symptoms, and that this varicosity feeds the symptomatic area e.g. ulcer or area of lipodermatosclerosis or persistent somatic symptoms; and
- The procedure requested is: Endovenous Laser Ablation (EVLA), Endovenous Radiofrequency Ablation (RFA) or Ligation and Stripping. Ambulatory phlebectomy may also be requested for AAGSV
- Note: Sclerotherapy may be considered medically necessary as an adjunct treatment for symptomatic varicose tributaries that remain after the medically necessary treatment of an axial vein that meets criteria above. Sclerotherapy is generally performed sometime after the primary procedure in order to assess residual tributaries, but maybe performed at the same time of the primary treatment if applicable. Sclerotherapy is limited to 3 sessions within 6 months of the axial vein procedure.

5.7.1.3 Superficial non-axial varicose veins

- When member meets symptoms criteria above;
- There is a duplex ultrasound of the deep and superficial venous system performed while the member is standing that documents competency of the axial system, and the nonaxial varicose vein has a diameter of ≥ 3 mm by ultrasound or physical exam and this varicosity feeds the symptomatic area e.g. ulcer or area of lipodermatosclerosis or persistent somatic symptoms; and
- The procedure requested is ambulatory phlebectomy.

5.7.1.4 Perforator veins

- When member has ulceration directly associated with the perforator;

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- If there is a main superficial vein connecting to this area with reflux and enlargement ≥ 3.5 mm there must be documentation that this vein has been successfully ablated/removed and despite this treatment that the ulcer has not healed or has recurred;
- There is duplex ultrasound of the deep and superficial venous system performed while the member is standing that documents competency of the axial system including no post thrombotic deep system incompetence;
- The procedure requested is subfascial interruption or Ligation, subfascial endoscopic perforator vein surgery (SEPS), EVLA, RFA, or ultrasound guided sclerotherapy.

5.8 Ears

5.8.1 Microtia

- Microtia or congenital underdevelopment of the external ear (ranges from mild deformity to complete absence/anotia)
- Microtia repair is explicitly considered reconstructive even if the issue is primarily anatomic (appearance) rather than functional

5.8.1.1 **Documentation Requirements**

- Diagnosis (e.g., microtia grade)
- Clinical notes describing deformity
- Surgical plan (e.g., staged reconstruction)
- Photos (often required for external deformities)
- Any functional concerns (hearing, infections, etc.)

5.8.1.2 **Additional Covered Components**

- Texas Children's Health Plan also recognizes related reconstructive steps as medically necessary when criteria are met:
  - Tissue expansion / flap reconstruction
  - Cartilage framework reconstruction
  - Staged auricular reconstruction procedures

5.8.1.3 **Age and Timing Considerations**

- Pediatric microtia reconstruction is approved after (typically ≥5–6 years) because of rib cartilage development.

5.8.1.4 **Limitations and Exclusions –** The following ear surgeries are considered cosmetic and are not covered services.

- Cosmetic reshaping without functional or psychosocial impact.
- Elective ear piercing correction.

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- Revision surgery solely for aesthetic reasons (unless functional complications exist, e.g., infection, pain, trauma).

6 Laser Hair Removal and Laser treatment for burns

6.1 Requests for the procedure will be reviewed by a medical director and medical necessity determined on a case-by-case basis.

7 TCHP does not provide coverage for cosmetic surgery procedures that do not meet criteria for medical necessity in this document including but not limited to:

7.1 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 authorization guideline.

7.2 Any procedure where the primary purpose is to enhance aesthetics

8 All requests for cosmetic surgery procedures that do not meet the guidelines referenced here will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

9 Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

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