MEDICAL POLICY

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MEDICAL POLICY DETAILS	
Medical Policy Title	**Cosmetic and Reconstructive Procedures**
Policy Number	**7.01.11**
Category	**Contract Clarification**
Original Effective Date	**12/02/99**
Committee Approval Date	**07/25/02, 12/11/03, 05/27/04, 12/02/04, 12/01/05, 12/07/06, 10/24/07, 10/23/08, 10/28/09, 12/09/10, 12/08/11, 09/04/12, 12/06/12, 12/12/13, 12/11/14, 12/10/15, 02/25/16, 04/27/17, 02/22/18, 02/28/19, 02/27/20, 10/22/20, 02/25/21, 02/17/22, 02/16/23, 02/22/24**
Current Effective Date	**02/22/24**
Archived Date	**N/A**
Archive Review Date	**N/A**
Product Disclaimer	• *Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

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

II. If a medical condition results from a cosmetic procedure, medically necessary services required to treat the medical condition will be **eligible for coverage**. Common, anticipated, side effects (e.g., nausea and vomiting that results in a prolonged hospital stay) are considered part of the cosmetic procedure and are **ineligible for coverage**.

III. Reconstructive procedures are performed on structures of the body affected by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.
   A. Reconstructive procedures incidental to or following surgery to treat an accidental injury, infection, or other disease of the part of the body involved**,** and that correct a functional deficit*, are considered **medically appropriate**. Supportive documentation is required.
   B. Reconstructive procedures related to a congenital disease or anomaly of a child that has resulted in a functional deficit* are considered **medically appropriate.** Supportive documentation is required.

*Functional deficit is defined as:
   A. Pain or other physical deficit that interferes with activities of daily living; or
   B. Impaired physical activity.

This policy does not address surgeries/procedures related to gender affirmation, refer to Corporate Medical Policy #7.01.84 Gender Affirming Surgery and Treatments for Commercial and Medicare Advantage Members

Refer to Corporate Medical Policy #11.01.15 Medically Necessary Services

Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services

POLICY GUIDELINES

The chart below provides examples of procedures that are generally, although not always, considered to be cosmetic.

When procedures are intended to improve impaired function/functional deficit, coverage will be considered. Adequate documentation must be provided upon request and prior to performing the procedure. This may include photographs, copies of consultations, and any other pertinent information.

For criteria related specifically to gender affirming procedures/surgeries, refer to Corporate Medical Policy #7.01.84 Gender Affirming Surgery and Treatments for Commercial and Medicare Advantage Members.

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Abdominoplasty		Refer to Corporate Medical Policy #7.01.53 Abdominoplasty and Panniculectomy
Acne: acne cysts, comedone extraction Refer to Chemical Peel section regarding chemical peel for acne.	10040 11900 - 11901 17340 **(E/I)**	Intralesional injection of painful acne cysts is considered **medically appropriate**. Surgical drainage of painful acne lesions (acne surgery) is considered **medically appropriate**. Comedone extraction is considered **not medically necessary**. The use of cryotherapy (carbon dioxide [CO_2] slush, liquid nitrogen) is considered **investigational** in the treatment of acne, due to the lack of peer-reviewed published studies supporting the efficacy of this treatment. Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions
Actinic keratoses	Refer to benign skin lesion codes.	The use of surgical or medical treatment methods, including, but not limited to cryosurgery, curettage, and excision, is considered **medically appropriate**. Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions
Alopecia		Refer to Corporate Medical Policy #2.01.36 Alopecia (Hair Loss)
Benign skin lesions This section does not refer to skin tags. Refer to Skin Tag Removal section.	11300 - 11313 (code range) 11400 - 11471 (code range) 17110 - 17111	When removed due to bleeding, pain, recent changes in color, enlargement, or exposure to frequent irritation, removal of benign skin lesion(s) is considered **medically appropriate**. When removed to improve appearance, the removal of benign skin lesion(s) is considered **not medically necessary**.
Blepharoplasty		Refer to Corporate Medical Policy #7.01.55 Blepharoplasty with or without Levator Muscle Advancement
Breast Asymmetry	19318 19325	Reduction mammoplasty/augmentation mammaplasty for: Treatment of severe asymmetry is considered **medically appropriate** when a functional deficit is documented. Surgery and reconstruction of the patient's other breast to produce a symmetrical appearance post-mastectomy or partial mastectomy (e.g., lumpectomy,

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
		segmentectomy, quadrantectomy) is considered **medically appropriate** and **covered as required under applicable law**. Treatment of other cases of asymmetry is considered **not medically necessary**. Treatment of other cases of breast augmentation is considered **not medically necessary.** Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery Refer to Corporate Medical Policy #7.01.39 Reduction Mammaplasty
Breast implants		Refer to the nationally recognized InterQual criteria.
Breast reconstruction		Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery
Breast reduction	19300 19318	Refer to Corporate Medical Policy #7.01.39 Reduction Mammaplasty Refer to the nationally recognized InterQual criteria for Reduction Mammaplasty, Male.
Chemical peel	**All are NMN:** 15788 - 15793 (code range) 17360	Chemical peel of any body area, including to improve acne, acne scars or uneven pigmentation, is considered cosmetic and, therefore, **not medically necessary**.
CoolSculpting (also known as cryolipolysis or fat freezing)		CoolSculpting or fat freezing is considered cosmetic and, therefore, **not medically necessary.**
Comedone extraction		Refer to Acne section
Congenital chest wall deformity (e.g., pectus excavatum, pectus carinatum)	21740 21742 21743	For reconstructive breast surgery after surgical mastectomy, including partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) for benign or malignant disease, refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery. Surgical correction of a congenital chest wall deformity is considered **medically appropriate** when a documented functional deficit exists. Functional deficits may include but are not limited to, atypical chest pain, cardiac abnormalities, pulmonary impairment, and, for those with pectus excavatum, a pectus severity index (PSI), also known as the Haller index, of 3.25 or greater. Surgical correction of a congenital chest wall deformity for cosmetic reasons is considered **not medically necessary**.
Congenital protruding ears	69300	Otoplasty is considered **medically appropriate** when a functional deficit is documented and when the distance from helical rim to mastoid is greater than or equal to 2.1 cm (normal is 1.5-2.0 cm).

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
Dermabrasion	15780 - 15783 (code range)	Dermabrasion is considered **medically appropriate** when a functional deficit exists following traumatic injury, previous surgery, or burns. Dermabrasion performed without a documented functional deficit is considered **not medically necessary** (e.g., acne, acne scars, tattoo removal, or uneven pigmentation).
Dermatoscopy, dermoscopy		Refer to the Optical diagnostic evaluation of skin lesions section.
Ear Piercing Traumatic laceration of ear and/or body piercing	69090 **(NMN)** 12001 12011	Ear piercing is considered cosmetic and, therefore, **not medically necessary** due to lack of a functional deficit. Repair, immediately post-injury, of traumatic laceration of ear and/or body piercing is considered **medically appropriate**. Earlobe repair or repair of a body site piercing to close a stretched pierce hole, in the absence of a traumatic injury, is considered cosmetic and, therefore, **not medically necessary**.
Eczema		Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions
Glabella (frown lines)	15826 **(NMN)**	Excision or correction of glabella is considered cosmetic and, therefore, **not medically necessary** due to lack of a functional deficit. Refer also to Rhytidectomy section.
Grafting of autologous fat or tissue	**All are NMN**: 15769 15771 15772 15773 15774	When performed for cosmetic reasons, grafting of autologous fat or tissue is considered **not medically necessary**. Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery
Hair removal for hirsutism or hypertrichosis		Refer to Corporate Medical Policy #2.01.38 Treatment of Hirsutism/Hypertrichosis (Hair Removal)
Hairplasty (hair transplant)	15775 **(NMN)** 15776 **(NMN)**	Hairplasty is considered **not medically necessary**. Refer to Corporate Medical Policy #2.01.36 Alopecia (Hair Loss)
Hemangioma	17106 17107 17108	Treatment of hemangioma(s), including laser therapy, is considered **medically appropriate** when a functional deficit is documented, Treatment of hemangioma(s) is considered **not medically necessary** without a documented functional deficit.
Hyperhidrosis surgery: includes endoscopic transthoracic sympathicotomy/ sympathectomy	32664 64821 – 64823 (code range) 97033 **(E/I)**	Surgical treatment of primary hyperhidrosis is considered **medically appropriate** for patients with medical complications such as skin breakdown with secondary infections (e.g., folliculitis or cellulitis requiring treatment with systemic antibiotics, or fissuring or cracking) **OR** documented significant biopsychosocial functional impairments (e.g., agoraphobia requiring mental

Indication/ Procedure	Code(s)	Coverage Criteria
(ETS), sympathectomy (radial artery, ulnar artery, superficial palmar arch), video assisted thoracic sympathectomy (VATS), and surgical excision of axillary sweat glands.		health intervention) with documentation of functional deficit, when **ALL** of the following criteria are met: • Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash; **AND** • Patient is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anti-cholinergic, beta-blockers, or benzodiazepines); **AND** • Patients has failed to adequately respond to treatment with botulinum toxin A (Botox A). *Note: Botox A is only FDA indicated, and therefore, a trial treatment is only required for patients diagnosed with axillary hyperhidrosis. Treatment of hyperhidrosis for cosmetic reasons is considered **not medically necessary**. The following treatments for hyperhidrosis are considered **investigational** because they have not been proven to be effective: acupuncture, axillary liposuction, homeopathy, hypnosis, iontophoresis, massage, psychotherapy, and phytotherapy (use of extracts from natural origin as medicines).
Keloid scars	See Benign skin lesion codes.	Treatment of keloid scars (including steroid injections, excision, and adjunctive post-operative radiation therapy) for significant functional deficit (e.g., pain or ulceration) is considered **medically appropriate**. Treatment of keloid scars without a documented functional deficit (nonfunctional reasons) is considered cosmetic and **not medically necessary**.
Labiaplasty/ Vulvectomy	56620 56625	Vulvectomy as part of surgery to treat cancer or pre-cancerous lesions (dysplasia) is considered **medically appropriate**. Vulvectomy is considered **not medically necessary** for any other indications. Labiaplasty is the reduction of the labia majora (outer lips of the vulva) or labia minora (inner lips of the vulva). Labiaplasty performed without a documented functional deficit is considered cosmetic and not medically necessary.
Laser resurfacing or laser scar revision	17999 0479T 0480T	Procedures related to the management of scarring, including post-mastectomy scars, are considered cosmetic, and therefore, **not medically necessary**, unless the scarring results in a functional deficit. Fractional ablative laser fenestration of burn and traumatic scars for functional improvement is considered **medically necessary** when there is documented evidence of significant functional impairment related to the scar (e.g., limited movement) and the treatment can be reasonably expected to improve the functional impairment. Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery
Lipectomy (includes suction lipectomy, liposuction)	15830 15832 – 15839 (code range)	Liposuction for lipedema can be considered a **medically appropriate** treatment option, when **ALL** of the following criteria are met: A. The patient has clinical exam findings that support the diagnosis of lipedema, which may include, but are not limited to: 1.bilateral symmetric adiposity in the extremities;

Indication/ Procedure	Code(s)	Coverage Criteria
	15876 - 15879 (code range)	2.non-pitting edema; 3.easy bruising; 4.tenderness to palpation at affected areas; **and** B. The patient has not responded to at least six (6) consecutive months of optimal medical management (e.g., conservative treatment with compression garments and manual lymph drainage); **and** C. The patient has a significant physical functional deficit (e.g., difficulty ambulating or performing activities of daily living) or medical complication (e.g., recurrent cellulitis); **and** D. The patient's plan of care is to wear compression garments as instructed and continue conservative treatment, post-operatively, to maintain benefits, including weight management. When performed for the sole purpose of removal of fat without a documented functional deficit (nonfunctional reasons), lipectomy is considered **not medically necessary**. This applies to removal of fatty tissue after weight loss for any reason, including bariatric surgery. However, lipectomy may be an integral part of other covered services. Refer to the nationally recognized InterQual criteria for Reduction Mammoplasty, Male.
Mastopexy (breast lift for pendulous breasts)	19316	Mastopexy is considered **medically appropriate** when a functional deficit is documented. Mastopexy without functional deficit is considered **not medically necessary**. Mastopexy in post-mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) patients is considered **medically appropriate** and covered as required by applicable law. Refer to Corporate Medical Policy #7.01.39 Reduction Mammaplasty
Optical diagnostic evaluation of skin lesions (e.g., complexion analysis, dermatoscopy [Dermascope, Episcope, MoleMax II, Nevoscope], epiluminescence microscopy, incidence light microscopy, melanomagram, multi-spectral imaging	96904 **(NMN)**	Optical diagnostic evaluation of skin lesions using direct inspection, photography, digitization of images, or computer-assisted analysis is considered **not medically necessary** as a technique to evaluate or serially assess pigmented skin lesions or to define peripheral margins of skin lesions suspected of malignancy prior to surgical excision. Dermatoscopy, also known as dermoscopy, describes a family of non-invasive techniques that allow in vivo microscopic examination of skin lesions and is intended to help distinguish between benign and malignant pigmented skin lesions. Multispectral digital skin lesion analysis (MSDSLA) uses a handheld scanner to shine visible light on the suspicious lesion. The data acquired by the scanner are analyzed by a data processor, and the characteristics of each lesion are evaluated using proprietary computer algorithms. Literature is inconclusive regarding the clinical role of optical diagnostic evaluation of skin lesions in the management of pigmented skin lesions, either to select or deselect lesions for excision or to define peripheral margins of

Indication/ Procedure	Code(s)	Coverage Criteria
[MelaFind], skin surface microscopy, total/whole body photography, Visia).		malignancy prior to surgical excision. There is a lack of evidence that demonstrates the impact of these technologies on clinical outcomes
Panniculectomy		Refer to Corporate Medical Policy #7.01.53 Abdominoplasty and Panniculectomy
Port wine birthmark		Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions
Psoriasis		Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions
Rhytidectomy (face lift)	15824 - 15829 (code range)	Rhytidectomy performed for correction of a documented functional deficit from facial nerve palsy is considered **medically appropriate**. Rhytidectomy treatments performed to remove wrinkles or glabellar frown lines, is considered cosmetic and, therefore, **not medically necessary**. See Subcutaneous injection of filling material and Glabella sections.
Rosacea, including erythema and telangiectasia.	17106 – 17108 (code range)	Treatment of rosacea, when there is a documented functional deficit, using procedures such as photoablation, laser treatment, sclerosing injections or ultraviolet light therapy, is considered **medically appropriate**. Treatment of rosacea for cosmetic reasons, using procedures such as photoablation, laser treatment, sclerosing injections or ultraviolet light therapy, is considered **not medically necessary**.
Scar revision		Revision of scars via surgery or intralesional steroid injection is considered **medically appropriate** when scars result in a functional deficit. Revision of acne or other scars for cosmetic reasons is considered **not medically necessary**.
Skin discoloration, including dyschromia		Treatment of skin discoloration is considered **medically appropriate** when a functional deficit is documented. Treatment of skin discoloration for cosmetic reasons is considered **not medically necessary**. See to Vitiligo and Port wine birthmark sections.
Skin removal of redundant or excessive skin	Refer to lipectomy codes.	Removal of redundant or excessive skin, including, but not limited to, redundant skin on the arms, thighs, back and buttocks, is considered **medically appropriate** when there is documentation of a significant functional impairment (e.g., cellulitis, abscess, or skin ulceration) that has been refractory to medical therapy (persistent, does not clear up then recur) for at least six months, including a minimum of two 10-day courses of appropriate systemic antibiotic

Indication/ Procedure	**Code(s)**	**Coverage Criteria**
		therapy. This includes removal of redundant skin caused by weight loss for any reason, including bariatric surgery. Removal of redundant or excessive skin for cosmetic reasons is considered **not medically necessary**. Removal of redundant skin caused by weight loss for any reason, including bariatric surgery, when there is not a functional deficit, is considered **not medically necessary**, as redundant skin is an expected outcome after significant weight loss. Refer to Corporate Medical Policy# 7.01.53 Abdominoplasty and Panniculectomy
Skin tag removal	11200 - 11201	When skin tags are located in areas subject to repeated irritation and bleeding, removal may be considered **medically appropriate**. Removal of skin tags without a functional deficit (nonfunctional reasons) is considered **not medically necessary**.
Spider veins of the face including telangiectasia and stellate angioma		See Rosacea section.
Subcutaneous injection of filling material (e.g., collagen, Hyaluronic acid, Prolaryn, Radiesse, Restylane, Sculptra)	11950 - 11954 (Code range) L8607, Q2026, Q2028	Dermal injections with products approved by the U.S. Food and Drug Administration (FDA) (e.g., poly-L-lactic acid [Sculptra], calcium hydroxylapatite [Radiesse]) for facial HIV lipoatrophy are considered **medically appropriate** for treatment of facial lipodystrophy syndrome (LDS) due to antiretroviral therapy in HIV-infected patients. Injection with Prolaryn is considered **medically appropriate** as an implant space-filling material for soft tissue augmentation in laryngeal procedures for vocal fold medialization and augmentation. Subcutaneous injection of filling material is considered cosmetic and, therefore, **not medically necessary**. If utilized for breast reconstruction, refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery.
Subcutaneous injection to dissolve unwanted small, localized areas of fat (e.g., deoxycholic acid [Kybella])	J0591 (**NMN**)	Subcutaneous injection for the reduction of submental fat (i.e., double chin) or other areas of fat is considered cosmetic and, therefore, **not medically necessary**.
Tattoos (e.g., decorative, make-up [e.g., eyebrows, eyeliner], self-induced, or intradermal introduction of	11920 – 11922 (code range)	The use of tattoos in breast reconstructive surgery is addressed in Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery. When excision or treatment of a tattoo is performed for nonfunctional reasons, it is considered **not medically necessary**. See Dermabrasion section.

Indication/ Procedure	Code(s)	Coverage Criteria
insoluble opaque pigments to correct color defects of skin).		See Vitiligo section.
Varicose veins (including telangiectasia)		For treatments other than vein stripping and ligation, refer to Corporate Medical Policy #7.01.47 Varicose Vein Treatments.
Vitiligo	96912	Treatment of vitiligo with autologous epidermal cell transplantation for repigmentation is considered **investigational**. Treatment of vitiligo of non-exposed areas, which may be protected from sun exposure, or treatment of vitiligo for cosmetic reasons, is considered **not medically necessary**. Refer to Corporate Medical Policy #8.01.21 Light and Laser Therapies for Dermatologic Conditions, regarding treatment with therapies such as excimer laser, PUVA, UVB, targeted phototherapy (e.g., XTRAC XL, VTRAC, BClear, Excilite, Excilite *u* and XeCL lamps).
Voice lifting procedures	No code(s)	Voice lifting procedures are performed in order to restore a youthful quality to patients' voices and can be performed with implants to bring vocal cords closer together or injections of fat or collagen to plump cords and restore youthful elasticity. Voice lifting procedures are considered **not medically necessary** due to lack of a functional deficit.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
Refer to table above.	

HCPCS Codes

Code	Description
Refer to table above.	

ICD10 Codes

Code	Description
Numerous codes	

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*Key article

KEY WORDS

Acne cysts, actinic keratoses, Activadose, benign skin lesion, chemical peel, complexion analysis, dermabrasion, dermatoscopy, Drionic, eczema, face lift, hyperhidrosis, keloid scars, labiaplasty, lipectomy, liposuction, otoplasty, port wine birthmark, Prolaryn, repigmentation, rhytidectomy, rosacea, scar revision, skin removal, skin tag removal, subcutaneous injection of filling material tattoo removal, voice lift.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There are currently National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and National Coverage Analysis (NCA) Decision Summaries that address various services considered to be cosmetic or reconstructive services. Please refer to the following websites for Medicare Members:

NCDs:

Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5): [https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=338#:~:text=NCD%20%2D%20Dermal%20Injections%20for%20the,Syndrome%20(LDS)%20(250.5)] accessed 01/10/24.

Laser Procedures (140.5):

[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=69&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=laser+procedures&KeyWordLookUp=Title&KeyWordSearchType=And&ncd_id=140.5&ncd_version=1&basket=ncd%25253A140%25252E5%25253A1%25253ALaser+Procedures&bc=gAAAABAAAAAA&] accessed 01/10/24.

Treatment of Actinic Keratosis (AKs) (250.4):

[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=129&ncdver=1&NCAId=1&ver=23&NcaName=Actinic+Keratoses&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=actinic+keratoses&KeyWordLookUp=Title&KeyWordLookUp=Title&KeyWordSearchType=And&KeyWordSearchType=And&ncd_id=140.5&ncd_version=1&basket=ncd%25253A140%25252E5%25253A1%25253ALaser+Procedures&bc=gAAAABAAIAAA&] accessed 01/10/24.

NCA Decision Memos:

Actinic Keratoses (CAG-00049N):

[https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=1] accessed 01/15/24.

Dermal injections for the treatment of facial lipodystrophy syndrome (FLS) (CAG-00412N): [http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=234&NcaName=Dermal+injections+for+the+treatment+of+facial+lipodystrophy+syndrome+(FLS)&NCDId=338&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7CCAL%7CNCD%7CMEDCAC%7CTA%7CMCD&ArticleType=Ed%7CKey%7CSAD%7CFAQ&PolicyType=Final&s=5%7C6%7C66%7C67%7C44&KeyWord=Dermal+Injections+for+the+Treatment+of+Facial+Lipodystrophy+Syndrome&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&IsPopup=y&bc=AAAAAAAACAAAAA%3D%3D&] accessed 01/10/24.