

Policy: MP240

Section: Medical Benefit Policy

Subject: Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

I. Policy: Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

II. Purpose/Objective:

To provide a policy of coverage regarding Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: Facial lipodystrophy Syndrome is characterized by facial wasting of fat under the skin of the face resulting in a gaunt or wasted appearance. Dermal fillers comprised of Poly-L-lactic acid and synthetic calcium hydroxylapatite can be used to restore a more normal facial.

LIMITATIONS:

Medicare and Medicaid Business Segments:

Dermal injections for the treatment of facial lipodystrophy syndrome is considered for coverage by mandate for the Medicare and Medicaid business segments. This service will be considered medically necessary only in HIV- infected insured individuals who manifest depression secondary to the physical stigma of HIV treatment.

EXCLUSIONS:

Dermal injections for the treatment of facial lipodystrophy syndrome will be considered cosmetic in nature and **NOT COVERED** for all business segments outside of the CMS mandate.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

11950 Subcutaneous injection or filling material 1cc or less

11951 Subcutaneous injection or filling material 1.1 cc to 5.0cc

11952 Subcutaneous injection of filling material 5.1 cc to 10.0cc

11954 Subcutaneous injection of filling material over 10.00cc

C9800 dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies.

G0429 Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)

Q2026 Injection, radiesse, 0.1 ml

Q2028 injection, sculptra, 0.5 mg

CMS-approved ICD-10 codes: B20, E88.1

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

Centers for Medicare and Medicaid (CMS). MLN® Matters. Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS) June 4, 2010. Accessed July 1, 2010 available at <http://www.medicarefind.com/searchdetails/Transmittals/Attachments/MM6953.pdf>

Centers for Medicare and Medicaid (CMS). NCD for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5). July 6, 2010. Accessed July 12, 2010 available at http://www.cms.gov/mcd/viewncd.asp?ncd_id=250.5&ncd_version=1&basket=ncd%3A250%2E5%3A1%3ADermal+Injections+for+the+Treatment+of+Facial+Lipodystrophy+Syndrome+%28LDS%29

Centers for Medicare and Medicaid (CMS). Proposed Decision Memo for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome CAG-00412N). December 23, 2009. Accessed July 12, 2010 available at <http://www.cms.gov/mcd/viewdraftdecisionmemo.asp?id=234>

Sturm LP et al. A Systematic Review of Permanent and Semipermanent Dermal Fillers for HIV-Associated Facial Lipoatrophy. 2009;23:699-714.

Doward LC et al. Impact of lipoatrophy on patient-reported outcomes in antiretroviral-experienced patients. AIDS Reader. 2008;18:242-246, 252-256, 262-265.

Valantin M-A et al. Poly lactic acid implants (New-Fill™) to correct facial lipoatrophy in HIV-infected patients: results of the open-label study VEGA. AIDS 2003; 17:2471–2477

Carruthers A, Carruthers J. Evaluation of injectable calcium hydroxylapatite for the treatment of facial lipoatrophy associated with human immunodeficiency virus. Dermatol Surg. 2008;34(11):1486-99.

Levy RM, Redbord KP, Hanke CW. Treatment of HIV lipoatrophy and lipoatrophy of aging with poly-L-lactic acid: a prospective 3-year follow-up study. J Am Acad Dermatol. 2008;59(6):923-33.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 7/12/10

Devised:

Reviewed: 7/11, 7/12, 7/13, 7/14, 7/15, 7/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.