KAISER PERMANENTE® Mid-Atlantic States	**Dermal Fillers** **Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. Procedure

Referral to plastic surgery for evaluation of drug related lipoatrophy/lipodystrophy for consideration of dermal fillers.

II. Clinical Indications for Referral

A. Lipoatrophy or lipodystrophy secondary to highly active antiretroviral therapy, ART.
B. Dermal injections of FDA-approved fillers (e.g., poly-L-lactic acid dermal injection (Sculptra) or calcium hydroxylapatite dermal injection (Radiesse)) are considered medically necessary for treating facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons;
C. Dermal fillers that do not meet the reconstructive benefit are considered cosmetic for all other indications.
D. Retreatments with FDA-approved fillers for facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons are approved when medically necessary per the specific instructions of the original filler utilized.

III. Limitations/Exclusions

Patient requires an evaluation with plastic surgery for approval of treatments.

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Approval History

Effective June 01, 2016, state filing no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC*	Date of Implementation
08/29/2016	08/29/2016
08/29/2017	08/29/2017
08/29/2018	08/29/2018
08/28/2019	08/28/2019
08/26/2020	08/26/2020
07/22/2021	07/22/2021
07/26/2022	07/26/2022
06/26/2023	06/26/2023
06/25/2024	06/25/2024

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any set of circumstances for an individual member.