MetroPlus Health

Policy and Procedure

Title: Treatment for HIV-Associated Facial Lipoatrophy with FDA-Approved Fillers	Division: Medical Management Department: Utilization Management
Approval Date: 12/21/2018	LOB: Medicare, UltraCare
Effective Date: 12/21/2018	Policy Number: UM-MP240
Review Date: 2/23/2024	Cross Reference Number:
Retired Date:	Page 1 of 4

1. POLICY DESCRIPTION:

Antiretroviral therapy can cause facial lipoatrophy. This is manifested by loss of fat along the cheeks, temples and orbits and is associated with social stigma. That stigma can lead to significant psychological duress.

In accordance with National Coverage Determination (NCD) 250.5) Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome, FDA approved filler agents poly-L-lactic acid (Sculptra) or calcium hydroxylapatite (Radiesse) are covered by Medicare and UltraCare to help restore natural appearance.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

Facial Lipodystrophy Syndrome (LDS): refers to a wasting of the fat stores in the face in some individuals with the Human Immunodeficiency Virus (HIV) taking anti-retroviral medication.

Lipodystrophy: a metabolic process whereby fat is either abnormally decreased or increased in the body. It can be caused by aging and medications, including antiretroviral therapy.

Lipoatrophy: a metabolic process whereby fat cells are lost beneath the deep dermis. Usually the loss is most evident in the face, limbs and chest.

Antiretroviral therapy: antiviral agents that inhibits various aspects of the lifecycle of the HIV virus, usually given in combination.

4. POLICY:

FDA-approved fillers are considered medically necessary for treating facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression.

5. LIMITATIONS/ EXCLUSIONS:

a. Dermal fillers that are not approved by the FDA for the treatment of LDS.
b. Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.
c. Coverage is only available for the Medicare and UltraCare LOBs.

6. APPLICABLE PROCEDURE CODES:

The codes for a filler and dermal injection must be accompanied by ICD-10 codes either B20 (AIDS) or Z21 (HIV infection) and E88.1 (lipodystrophy).

CPT	Description
G0429	Dermal injection
Q2026	Radiesse
Q2028	Sculptra

7. APPLICABLE DIAGNOSIS CODES:

CODE	Description
B20	Acquired Immunodeficiency Syndrome (AIDS)
Z21	HIV Infection
E88.1	Lipodystrophy syndrome

8. REFERENCES:

1. **CMS: National Coverage Determination (NCD) for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5)**
   https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=338

2. **Pub 100-04 Medicare Claims Processing, Transmittal 2105, November 24, 2010, Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2105CP.pdf

3. Medicare Claims Processing Manual Chapter 32 – Billing Requirements for Special Services (Rev. 11759, 12-21-22), 260 - Dermal Injections for Treatment of Facial Lipodystrophy Syndrome https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c32.pdf

4. Jagdeo J, Ho D, Lo A et al. A systematic review of filler agents for aesthetic treatment of HIV facial lipoatrophy (FLA). J Am Acad Dermatol 2015;73:1040-54.

5. Moyle G, Lysakova L, Brown S et al. A randomized open-label study of immediate versus delayed polyactic acid injections for the cosmetic management of facial lipoatrophy in persons with HIV infection. HIV Medicine 2004;5:82-87.

REVISION LOG:

REVISIONS	DATE
Creation date	12/21/2018
Annual review	10/25/2019
Annual Review, update applicable LOBs covered	1/29/2021
Annual review	1/28/2022
Review- remove Medicaid LOB coverage	2/28/2022
Annual Review	2/28/2023
Annual Review, modified to comply with Medicare NDC 250.5	2/23/2024

Approved: **Date:**

Sanjiv Shah, MD
Chief Medical Officer

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Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication. MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.