Sentara Health Plans

Medicaid

Dermal Fillers

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Effective Date	1/2011
Next Review Date	9/2024
Coverage Policy	Medical 201
Version	7

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medical necessity of Dermal Fillers.

Description & Definitions:

Dermal filler is a substance injected into various parts of the body to smooth skin and wrinkles.

Criteria:

Dermal fillers are considered medically necessary for individuals with **All** of the following:

- Individual is over the age of 21
- Individual has a diagnosis of human immunodeficiency virus (HIV)
- Individual has facial lipodystrophy caused by antiretroviral medications which contributes significantly to depression
- The dermal filler to be used is approved by the Food and Drug Administration (FDA) for treatment of facial lipodystrophy.
- Dermal filler is **1 or more** of the following:
    - Sculptra
    - Radiesse

Dermal Fillers is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Belotero Balance
- Captique
- Collagen

- Elevess
- Esthélis
- Hylaform
- Juvederm
- Juvederm Ultra 2, 3 or 4
- Kybella
- Perlane
- Prevelle
- Puragen
- Restylane
- Revanesse Versa
- Stylage

Coding:

Medically necessary with criteria:

Coding	Description
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

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2021: November
- 2019: November
- 2016: March
- 2014: February, July
- 2013: July
- 2011: September

Reviewed Dates:

- 2023: September
- 2022: September
- 2020: November
- 2018: June
- 2016: July
- 2015: July
- 2012: August

Effective Date:

- January 2011

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect,

physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Radiesse, Sculptra, Dermal Fillers, shp medical 153, vocal cord, SHP medical 201, human immunodeficiency virus, HIV, facial lipodystrophy