Overview
The purpose of this document is to describe the guidelines Neighborhood Health Plan (NHP) utilizes to determine medical necessity for treatment of HIV-associated lipodystrophy syndrome. The treating provider must request prior authorization and provide documentation as outlined in this policy.

Coverage Guidelines
NHP covers medically necessary medical or drug* treatments to correct or repair disturbances of body composition related to HIV-associated lipodystrophy syndrome, in accordance with Massachusetts State Mandate An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment, when the member meets the criteria as outlined in this policy.

Members must meet the general coverage criteria and the criteria for any specific procedure below:

### Face
- Dermal filler injections (Sculptra and Radiesse) for facial lipoatrophy
- Autologous fat transplantation

### Abdomen
- Egrifta™ for lipohypertrophy of the abdomen*

### Chest
- Liposuction to reduce lipohypertrophy

### General Coverage Criteria
NHP covers medically necessary treatments and procedures noted above for HIV-associated lipodystrophy syndrome when the following are met:

1. The member has a diagnosis of HIV or AIDS; and
2. The medical condition is well documented by clinical notes (photos may be required), that includes a diagnosis of HIV-associated lipodystrophy syndrome, and specifically states that the treatment is necessary for correcting, repairing, or ameliorating the effects of HIV-associated lipodystrophy syndrome; and
3. The requested procedure can be reasonably expected to treat the specific part of the body affected by HIV-associated lipodystrophy syndrome.

### Specific Criteria for Selected Procedures

#### Face
NHP considers Sculptra and Radiesse (the FDA-approved soft tissue fillers dermal injections for facial lipoatrophy due to HIV-associated lipodystrophy syndrome), as well as autologous fat transplantation, to be medically necessary when the general coverage criteria are met. In addition, the provider performing the procedure must be a contracted in-network provider.

Note: Subsequent injections with the above fillers or autologous fat transplantation may be considered medically necessary however prior authorization and clinical notes and documentation from the treating provider are required.

*NHP’s retail pharmacy benefit covers Tesamorelin (Egrifta™) for the treatment of HIV-associated lipodystrophy syndrome, specifically lipohypertrophy of the abdomen through the pharmacy program.
Exclusions
1. Semipermanent dermal fillers that are not approved by the FDA for the treatment of facial lipoatrophy due to HIV-associated lipodystrophy syndrome.
2. Semipermanent dermal fillers or autologous fat transplantation that is used for any indication other than facial lipoatrophy due to HIV-associated lipodystrophy syndrome.
3. See General Exclusions

Chest
Liposuction
NHP covers medically necessary liposuction to reduce lipohypertrophy of the chest caused by HIV-associated lipodystrophy syndrome when the member meets the general coverage criteria.

Gynecomastia Surgery
NHP covers medically necessary gynecomastia surgery to reduce lipohypertrophy of the chest caused by HIV-associated lipodystrophy syndrome when the member meets the general coverage criteria and when:
1. Liposuction is not indicated to treat HIV-associated lipohypertrophy of the chest.

Exclusions
1. Breast surgeries or procedures performed outside the treatment of HIV-associated lipodystrophy syndrome solely to enhance a member’s appearance or to counteract appearance that occurs through the natural aging process, in the absence of any signs or symptoms of functional abnormalities and/or associated medical complication is considered cosmetic and is not a covered benefit, unless specifically noted in the coverage criteria.
2. See General Exclusions

Abdomen
Egrifta™ Injections
Under NHP’s retail pharmacy benefit, Tesamorelin (Egrifta™) is covered for the treatment of HIV-associated lipodystrophy syndrome, specifically lipohypertrophy of the abdomen when criteria are met and when authorized through the pharmacy program.

Neck/Upper Back
Liposuction
NHP covers medically necessary liposuction to reduce lipohypertrophy of the neck caused by HIV-associated lipodystrophy syndrome when the member meets the general coverage criteria.

Exclusions
See General Exclusions

General Exclusions
1. When the member does not meet the general coverage criteria;
2. Coverage not associated with the HIV-associated lipodystrophy syndrome meets the criteria under NHP’s Reconstructive & Cosmetic Surgery Policy;
3. For members with a diagnosis of HIV-Associated Lipodystrophy syndrome, coverage of cosmetic surgery and procedures and non-surgical cosmetic dermatology procedures that are solely to enhance a patient’s appearance in the absence of any signs or symptoms of functional abnormalities; and/or associated medical complication is considered cosmetic and is not a covered benefit, unless specifically noted otherwise in this coverage criteria. These include but are not limited to the following:
   a. Hair removal
   b. Facial implants
   c. Skin tightening
   d. Chemical peels
   e. Laser skin resurfacing
   f. Thyroid cartilage shaving surgeries
4. Procedures for facial or body augmentation/reduction not associated with HIV-associated lipodystrophy syndrome

Definitions

**Autologous fat transplantation** — Autologous fat transplantation involves harvesting of a small intact lump of fatty tissue from the abdomen, cervicodorsal area, or elsewhere, that can be processed into small fat "parcels" that are injected by a syringe with local anesthesia.

**HIV-associated Lipodystrophy Syndrome:** A syndrome that occurs in HIV-infected patients in response to some antiretroviral (ARV) drug therapy, characterized by abnormal fat metabolism and deposition. It is not a single syndrome but rather can be composed of three components that present together, or alone: lipoatrophy, lipohypertrophy, and metabolic disturbance (insulin resistance, hypercholesterolemia, and hypertriglyceridemia).

**Egrifta® (tesamorelin injection):** Egrifta is a self-administered human growth hormone that was approved by the FDA in 2010 for the treatment of lipodystrophy in HIV infected adults. Egrifta induces and maintains a reduction of excess visceral abdominal fat.

**Facial Lipoatrophy:** Facial lipoatrophy is characterized by loss of the buccal and/or temporal fat pads, leading to facial skeletonization with concave cheeks, prominent nasolabial folds, periorbital hollowing, and visible facial musculature. Also referred to as facial lipodystrophy syndrome (LDS), and facial wasting. The two antiretroviral drugs associated with causing HIV Facial Lipoatrophy are Zidovudine (Brand name: Retrovir; a component of Combivir and Trizivir) and Stavudine (Brand name: Zerit).

**Lipoatrophy:** Loss of fat from specific areas of the body, especially from the face, buttocks, and limbs.

**Lipohypertrophy:** Abnormal accumulation of fat, particularly within the abdomen, breast, dorsocervical region (back of neck and shoulders), front of the neck (“horse collar”) and subcutaneous tissue (peripheral lipomatosis).

**Soft Tissue Fillers:** Soft tissue fillers, also known as injectable implants, dermal fillers, or wrinkle fillers are medical device implants approved by the FDA for use in helping to create a smoother and/or fuller appearance in the face, including nasolabial folds, cheeks and lips and for increasing the volume of the back of the hand.

**Radiesse (Calcium hydroxylapatite):** Radiesse is a filler material for correction of moderate to severe facial wrinkles and folds. It was approved by the FDA in 2006 for facial lipoatrophy in people with HIV lipodystrophy. The effects of this material last approximately 18 months.

**Sculptra (Poly-L-lactic acid):** Sculptra is a long lasting filler material that is given in a series of injections over a period of several months. The effects of Sculptra generally become increasingly apparent over time (over a period of several weeks) and its effects may last up to 2 years. In 2004 the FDA approved Sculptra as injectable filler to correct facial lipoatrophy in people with HIV lipodystrophy.

Related Policies

- [Breast Surgeries Medical Policy](#)
- [Reconstructive and Cosmetic Procedures](#)

<table>
<thead>
<tr>
<th>Authorized CPT/HCPCS Codes</th>
<th>Code Description</th>
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</thead>
<tbody>
<tr>
<td>11950</td>
<td>Subcutaneous injection of filling material (eg, collagen); 1 cc or less</td>
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<tr>
<td>11951</td>
<td>Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc</td>
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<td>Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc</td>
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<td>Suction assisted lipectomy; upper extremity</td>
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<tr>
<td>15879</td>
<td>Suction assisted lipectomy; lower extremity</td>
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</tbody>
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Effective
September 2018: Removed exclusion: liposuction for HIV associated lipodystrophy of the abdomen.
December 2017: Annual Update.
November 2016: Effective date.

References:
16. M.G.L. Chapter 233: An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment
30. Wanke C. Epidemiology, clinical manifestations, and diagnosis of HIV-associated lipodystrophy [Internet] 2015 [cited 2016 Oct 11];