## Medical Policy
### Reconstructive and Cosmetic Procedures

**Document Number:** 012

<table>
<thead>
<tr>
<th>Authorization required</th>
<th>Commercial and Qualified Health Plans</th>
<th>MassHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hours of service or next business day</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>No notification or authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Overview
The purpose of this document is to describe the guidelines Neighborhood Health Plan utilizes to determine medical appropriateness of procedures considered reconstructive and cosmetic in nature. The treating specialist must request prior authorization for reconstructive and cosmetic procedures.

## Coverage Guidelines
NHP generally provides coverage when the surgery or procedure is reconstructive in nature, i.e. needed to improve the functioning of a body part, treat an associated medical complication, or is otherwise medically necessary, even if the surgery or procedure may also improve or change the appearance of a portion of the body. While this policy addresses many common procedures, it does not address all specific procedures that may be considered cosmetic in nature, and therefore excluded from coverage. NHP reserves the right to deny coverage for any procedures that are considered cosmetic and not medically necessary. NHP excludes coverage of cosmetic surgery and procedures that are performed primarily to improve or enhance a person’s appearance as not medically necessary.

NHP covers medically necessary reconstructive surgery and procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease when there is a physical functional impairment or ongoing medical complication that is expected to be improved upon with the requested procedure. NHP will also consider reconstructive/restorative procedures of the face to correct severe disfigurement under the circumstances described below. NHP covers reconstructive surgery, subject to benefit limitations.

Reconstructive procedures require prior authorization in order to determine the benefit coverage and/or the medical necessity of the procedure. Simultaneous procedures may be medically necessary to provide functional improvement. When more than one procedure is requested, documentation that satisfies the criteria for each procedure must be submitted before services are authorized. For some conditions, a planned staged procedure may be medically appropriate, but for most conditions, only the initial reconstructive procedure will be authorized unless a significant functional impairment or ongoing medical complication remains, and medical review criteria are met.

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

**Eyelid(s)**
- Blepharoplasty/Upper Blepharoptosis Repair for visual field impairment
- Upper or Lower Blepharoplasty for Non-Visual Field issues
- Brow Ptosis Repair

**Nose**
- Rhinoplasty
- Septoplasty

**Facial**
See [Oral and Maxillofacial Surgery and Procedures Medical Policy](#)

**Chest**

See *Breast Surgeries Medical Policy* for Breast Surgeries and tattooing an areola
- Pectus excavatum
- Pectus carinatum
- Poland syndrome

**Abdomen**
- Panniculectomy

**Skin**
- Skin Redundancy: Removal on arms, legs, and buttocks
- Dermabrasion

**Appendages**
- Supernumerary Digit Removal

**Veins**
- Varicose Vein Treatment

**General Coverage Criteria**

NHP covers medically necessary reconstructive procedures when the following are met:
1. The medical condition or complication and the functional impairment is well documented by supportive testing and clinical notes (photos may be required, and when required may need to be emailed or mailed for visual clarity and quality); and
   a. If the procedure is listed above or in the criteria below, the specific criteria must also be met; or
   b. If the procedure is not listed above or in the criteria below, the medical necessity will be reviewed on an individual basis.
2. The requested procedure can be reasonably expected to resolve the medical condition or complication and functional impairment.

Note: For some conditions, a planned staged procedure may be medically appropriate, but for most conditions only the initial reconstructive procedure will be authorized unless a significant functional impairment or ongoing medical complication remains, and medical review criteria are met.

**Trauma to the Face**

NHP covers medically necessary restorative procedure for the face when the all of the following are met:
1. The circumstances of the accidental trauma and the degree of injury are well documented by supportive testing and clinical notes. (Photos may be required, and when required, may need to be emailed or mailed for visual clarity and quality).
2. The procedure must be requested and performed within 12 months of the accidental injury; or
   a. For children who have not reached full maturity (i.e. age 16 or less), the medical record must document that a delay greater than 12 months for performing the initial restorative procedure was required in order for growth to be complete; or
   b. For any other delay greater than 12 months, the medical record must document that the postponement of the initial restorative procedure was required in order for optimal reconstruction, healing, and remodeling.
3. The requested procedure can be reasonably expected to have a successful outcome.

Note: Only the initial restorative procedure will be authorized, unless a significant functional impairment or ongoing medical complication remains, and medical review criteria for a reconstructive procedure are met.

**Exclusions**

See *General Exclusions*

**Specific Criteria for Selected Reconstructive Procedures**

**Eyes**

**Blepharoplasty/Upper Blepharoptosis Repair for visual field impairment**

As of February 20, 2017 medical necessity for Blepharoplasty is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at [NHP.Net](http://NHP.Net) and click the InterQual® Criteria Lookup link under the Resources Menu.
Exclusions
See General Exclusions

Upper or Lower Blepharoplasty for Non-Visual Field issues
As of February 20, 2017 medical necessity for upper or lower blepharoplasty for non-visual field issues is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions
See General Exclusions

Brow Ptosis Repair
As of February 20, 2017 medical necessity for brow ptosis repair is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu.

Nose
Rhinoplasty
As of February 20, 2017 medical necessity for rhinoplasty is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu.

See General Exclusions

Septoplasty
As of February 20, 2017 medical necessity for septoplasty is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu.

Chest
Pectus Excavatum
As of February 20, 2017 medical necessity for pectus excavatum repair is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu.

Pectus Carinatum
Surgical repair is generally not medically necessary, as the condition is asymptomatic in the vast majority of people. NHP covers medically necessary surgical repair when:

1. The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise;
2. The medical record clearly documents the degree of deformity (via Haller index or other) and its direct relationship to the symptoms including supportive cardiopulmonary testing such as pulmonary function testing; and;
3. The member has completed bone growth, generally when greater than or equal to 15 years of age.

Exclusions
1. Male pectoral augmentation for the purpose of enhancing the chest region unrelated to the surgical repair of the chest wall as covered in this policy or the Breast Surgeries policy.
2. See General Exclusions

Poland Syndrome
See Breast Surgeries Clinical Coverage Criteria for breast reconstruction for members with Poland Syndrome. NHP covers medically necessary surgical repair of associated chest wall deformity when one of the following are met:

1. The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise; or
2. The medical record documents chest wall defects in which the chest viscera are exposed and susceptible.

Exclusions
1. Costal aplasia or hypoplasia without physical functional impairment.
2. Male pectoral augmentation for the purpose of enhancing the chest region unrelated to the surgical repair of
   the chest wall as covered in this policy or the Breast Surgeries policy.
3. See General Exclusions

Abdomen

Panniculectomy
As of February 20, 2017 medical necessity for panniculectomy of the abdomen is determined through McKesson’s
InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria
Lookup link under the Resources Menu.

Skin

Skin Redundancy: removal on arms, legs, and buttocks
See panniculectomy above for removal of redundant skin of abdomen. See Breast Surgeries Clinical Coverage Criteria for
breast reduction criteria.

NHP covers medically necessary removal of redundant skin when criteria 1 and 2 are met:
1. The redundant skin is the result of weight loss of at least 75 pounds that has been stable for at least 6 months,
   and if the weight loss occurred as a result of bariatric surgery, the member must be at least 12 months post
   bariatric surgery.
2. There is written and photographic supporting documentation that the occlusive redundant skin directly causes
   one of the following:
   a. Symptomatic intertriginous ulcerations or macerations that are unresponsive to good personal hygiene
      and well documented optimal physician-supervised local treatment and that continually persist for a
      period of at least six months despite this care and treatment. Required lateral and frontal photos must
      demonstrate a significantly redundant and occlusive skin fold, and additional photos must document the
      presence of intertriginous skin ulceration and maceration; or
   b. Recurrent bacterial skin infections (at least 2 in a 12 month period) directly related to the redundant
      skin, which required systemic antibiotics. Required lateral and frontal photos must demonstrate a
      significantly redundant and occlusive skin folds.

Note: Liposuction is often an integral part the surgical removal of excessive skin this is not separately reimbursed.

Exclusions
See General Exclusions

Dermabrasion
NHP covers medically necessary dermabrasion:
1. To remove superficial basal cell carcinomas and pre-cancerous actinic keratoses when conventional methods of
   treatment (cryotherapy, curettage, excision, and 5-FU) are impractical due to the number and distribution of the
   lesions, or
2. For restoration after previous medically necessary surgery.

Exclusions
1. Dermabrasion or other cosmetic dermatologic procedures performed for the removal of acne, acne scars,
   wrinkles, or uneven pigmentation is not considered medically necessary and is not a covered benefit.
2. See General Exclusions

Scar Revision (including Keloid Revision)
As of February 20, 2017 medical necessity for scar revision is determined through McKesson’s InterQual® criteria. Photo
documentation may be required. To access the criteria, log in to NHP’s provider website at NHP.Net and click the
InterQual® Criteria Lookup link under the Resources Menu.

Skin Lesion Removal
NHP covers medically necessary skin lesion removal in the following situations:
1. Any lesion clinically suspicious for malignancy;
2. Any presumably benign lesion that grows or enlarges, begins to bleed or ulcerate or that is exposed to frequent
   irritation; or
3. Nevi when the rationale is to reduce the risk of malignant transformation.

Notes: Photo documentation may be required.

The following does not require prior authorization:
- Biopsy, skin lesion biopsy, skin lesion, each additional
- Excisions and simple closure, benign lesions
- Excision, malignant lesions
- Injection into skin
- Destruction of benign lesion(s) other than skin tags or cutaneous vascular proliferative lesions

Exclusions
See General Exclusions

Skin Tag Removal
NHP covers medically necessary removal of a skin tag. The medical record should clearly document the size, location and characteristics of the skin tag and one or more of the following conditions is present:
1. Chronic, recurrent, or persistent bleeding, intense itching, and/or pain.
2. Physical evidence of inflammation, e.g.; purulence (containing pus), oozing, edema, erythema (redness).
3. There is a clinical uncertainty as to the likely diagnosis, particularly where malignancy (cancer) is a realistic consideration based on the appearance or growth.
4. The skin tag is in an anatomical region subject to recurrent physical trauma and that such trauma has, in fact, occurred.
5. The skin tag obstructs an orifice or clinically restricts vision.
6. A preauricular skin tag containing both skin and cartilage

Note: Skin tag removal does not require prior authorization.

Hemangioma Destruction
NHP covers medically necessary hemangioma destruction when the medical record clearly documents the size, location, and characteristics of the hemangioma and one of the following:
1. The hemangioma is causing a functional impairment of vital structures (e.g. impaired vision or astigmatism due to eyelid or periorbital hemangiomas; auditory impairment and secondary speech delay due to hemangiomas in the ear); or
2. The hemangioma has recurrent bleeding, ulceration, or infection; or
3. The hemangioma is pedunculated; or
4. The hemangioma is associated with Kasabach-Merritt syndrome.

Note: photo documentation may be required.

Exclusions
1. Treatment (i.e. laser) of congenital capillary hemangiomas that are naturally resolving and in the absence of interference with a vital structure (eye, airway) or with documented recurrent infection or significant bleeding requiring medical intervention.
2. See General Exclusions

Port Wine Stain Treatment by Laser
NHP covers medically necessary port wine stain treatment by laser when the medical record clearly documents the size, location and characteristics of the port wine stain, and one of the following:
1. The port wine stain is on the face and neck; or
2. The port wine stain has recurrent bleeding, ulceration, or infection.

Note: photo documentation may be required.

Exclusions
See General Exclusions
Appendages

Supernumerary Digit Removal
NHP covers medically necessary removal of supernumerary digits for members up to the age of 19 years.

Exclusions
1. The member is over 19 years of age.
2. See General Exclusions

Veins

Varicose Vein Ligation and Stripping, Ablation, Ambulatory Phlebectomy, Sclerotherapy
Medical necessity for varicose vein treatment is determined through McKesson’s InterQual® criteria. Photo documentation may be required. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions
See General Exclusions

General Exclusions
NHP does not provide coverage for reconstructive procedures for conditions that do not meet the criteria noted above, including but not limited to:
1. 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.
2. Any procedure where the primary purpose is to enhance aesthetics, including but not limited to:
   a. Hair removal
   b. Hair transplantation
   c. Liposuction
   d. Facial implants
   e. Calf implants
   f. Skin tightening
   g. Chemical peels
   h. Laser skin resurfacing
3. Thyroid cartilage shaving surgeries or procedures performed primarily for psychological or emotional reasons.

Related Policies
- Breast Surgeries Medical Policy
- Dermatology Provider Payment Guideline
- Oral and Maxillofacial Surgery and Procedures Medical Policy
- Phototherapy and Photochemotherapy for Dermatologic Conditions Medical Policy

Effective
May 2017: Changes reflect the addition of InterQual® varicose veins treatment criteria.
February 2017: Changes reflect the addition of InterQual® eye, nose, chest, abdomen, and scar revision criteria.
October 2016: Annual review.
October 2015: Annual Review and updates included expanded list of cosmetic surgery and procedures and non-surgical cosmetic dermatology procedures for the primary purpose of enhancing aesthetics, and clarification of varicose vein criteria References updated.
October 2014: Annual review. Updates included reformatted and clarified criteria. Added general criteria, criteria for the face, skin redundancy removal to arms legs and buttocks, and new criteria for varicose veins. Added procedures under coverage guidelines.
March 2013: Annual review.
February 2012: Annual review.
February 2011: Annual review.
January 2010: Annual review.
January 2009: Annual review.
January 2008: Annual review.
January 2007: Annual review.
December 2006: Annual review.
November 2005: Effective Date.

References:


American Society of Plastic Surgeons, Recommended Criteria for Third-Party Payer Coverage, downloaded from http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Recommended_Insurance_Coverage_Criteria.html, retrieved 12/06 12/07, 12/08, 1/09, 1/10, 1/11, 1/12, 1/13


Division of Medical Assistance, 2003, Communications from Annette Hanson, MD, Medical Director

Division of Medical Assistance Guidelines for Medical Necessity Determination for Mastectomy for Gynecomastia, October 1, 2005, retrieved 1/12

Division of Medical Assistance Guidelines for Medical Necessity Determination for Panniculectomy, July 31, 2008, retrieved 1/10, 1/12


Paravastu, Sharath Chandra Vikram, and P. Dominic F. Dodd. Endovenous ablation therapy (LASER or radiofrequency) or foam sclerotherapy versus conventional surgical repair for short saphenous varicose veins. The Cochrane Library. 2013


