BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Cosmetic, Reconstructive, and Restorative Services

Policy Number: OCA 3.69
Version Number: 21
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☒ NH Medicaid	☒ MassHealth ACO
☒ NH Medicare Advantage	☒ MassHealth MCO
	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The purpose of this policy is to set forth the Plan's clinical guidelines for coverage related to cosmetic services and reconstructive and restorative services in order to ensure consistent application of benefit decisions across the Plan. All Plan policies are developed in accordance with state, federal, and accrediting organization guidelines and requirements, including National Committee for Quality Assurance (NCQA). The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition.

The Plan's *Prior Authorization/Notification Requirements Matrix* includes a list of services that require prior authorization. Review the Plan's *Prior Authorization CPT Code Look-up Tool* and *Prior Authorization HCPCS Code Look-up Tool* for the prior authorization requirement for each of the service's applicable, industry-standard billing code(s). The Plan's prior authorization matrix, CPT/HCPCS code look-up tools, medical policies, and reimbursement policies are available at www.bmchp.org for BMC HealthNet Plan members (including Senior Care Options member) and posted at www.wellsense.org for WellSense Health Plan members.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

It will be determined during the Plan's prior authorization process if the requested service is considered a cosmetic service or reconstructive and restorative service. The Plan's *Medically Necessary* medical policy, policy number OCA 3.14, specifies the product-specific definitions of medically necessary treatment. Review the product-specific definition of experimental or investigational treatment in the *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12. The Plan's *Clinical Review Criteria* administrative policy, policy number OCA 3.201, includes product-specific definitions of clinical review criteria, a summary of the Plan's procedure for applying clinical review criteria to services that require prior authorization, and specifies which entities are responsible for the development, implementation, and monitoring of the Plan's clinical review criteria. The Plan's *Clinical Technology Evaluation* administrative policy, policy number OCA 3.13, includes definitions for evidence-based medicine and medical technology assessment, and the policy outlines the process for evaluating new technology and the new application of existing technology. Review the Plan's applicable *Clinical Trials* reimbursement policy if the requested services are related to a clinical trial: policy number 4.134 for BMC HealthNet Plan members, policy number SCO 4.134 for Senior Care Options members, and policy number WS 4.12 for WellSense Health Plan members.

The following Reconstructive and Restorative Services Grid can be used as a guide to determine whether the proposed service is a cosmetic service (not covered) or a reconstructive and restorative service (and therefore covered based on medical necessity). If "yes" is the answer to all three (3) questions listed in the table below, then the proposed service is medically necessary and covered; only one (1) "yes" response is required for each of the three (3) questions for the service to be considered medically necessary. If "no" is the answer to ANY of the three (3) questions specified in the table below, then the proposed service is a cosmetic service and not covered.

Reconstructive and Restorative Services Grid (Questions 1-3 Require "Yes" Response):

Question 1: Is there a physical functional impairment or is pain present? At least one (1) "Yes" response is required for question 1.			**Question 2: Does the condition meet the definition of a reconstructive and restorative service? At least one (1) "Yes" response is required for question 2.**		
Category for Question 1	*Yes*	*No*	*Category for Question 2*	*Yes*	*No*
• Ambulation			• Accidental traumatic injury		
• Communication, speech			• Anatomic variant		
• Nutrition, swallowing			• Birth abnormality		
• Pain			• Congenital defect		
• Respiration, airway, control of secretions			• Disease process and associates symptoms (e.g., infection, bleeding, organ or sensory dysfunction)		
• Skin integrity or functional impairment associated with a pathological process			• Post-mastectomy		

• Vision			• Post-therapeutic intervention		

Question 3: Can the proposed service be reasonably expected to improve the physical functional impairment or relieve the pain? A "Yes" response is required for question 3.		
Category for Question 3	*Yes*	*No*

Clinical Criteria

It is the responsibility of the Plan's Medical Directors/Physician Reviewers and Clinical Pharmacists (where applicable), under the direction of the Plan's Chief Clinical Officer, to determine if the requested services are cosmetic or restorative and reconstructive. Review ALL items 1 through 5 for Plan guidelines on when services are categorized as cosmetic or reconstructive and restorative.

1. **Cosmetic services** are devices, drugs, procedures, surgeries, and/or treatments considered NOT medically necessary by the Plan, as specified in the Product-Specific Definitions section of this policy. **Services that meet the applicable, product-specific definition of reconstructive and restorative services are NOT considered cosmetic**. Examples of services **generally** considered cosmetic include but are not limited to ANY of the following, as specified below in items a through c:

   a. Ear/body piercing; OR

   b. Rhytidectomy (facelift procedure); OR

      Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the Plan's applicable clinical review criteria included in a Plan medical policy, Plan-adopted InterQual© criteria, or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of rhytidectomy for the treatment of gender dysphoria.

   c. Treatment of scars (e.g., hypertrophic scars, keloids).

      Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the Plan's applicable clinical review criteria included in a Plan medical policy, Plan-adopted InterQual© criteria, or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes InterQual© criteria to determine the medical necessity of scar revisions (e.g., hypertrophic scars, keloids).

2. **Reconstructive and restorative services** (as specified in the Product-Specific Definitions section of this policy) for eligible members will be considered medically necessary and therefore covered by the Plan when BOTH criteria in item a and item b are met:

a. There is documented evidence in the member's medical record of pain or significant physical functional impairment related to the diagnosis; AND

b. The treatment can be reasonably expected to improve the physical functional impairment or relieve the pain.

3. The **determination of whether a proposed service would be considered cosmetic or reconstructive/restorative must always be made in the context of the applicable benefit language** found in the applicable documents listed in items a through e for the Plan member (and in the Product-Specific Definitions section of this policy):

   a. For a MassHealth member, reference the MassHealth Member Handbook in effect at the time of the prior authorization review available at www.bmchp.org; OR

   b. For a Senior Care Options member, reference the member's applicable member handbook in effect at the time of the prior authorization review available at www.SeniorsGetMore.org; OR

   c. For a member enrolled in a BMC HealthNet Plan product offered by the Plan (except for MassHealth or Senior Care Options products), reference the member's applicable Evidence of Coverage in effect at the time of prior authorization review available at www.bmchp.org; OR

   d. For a WellSense New Hampshire Medicaid member, reference the Member Handbook in effect at the time of the prior authorization review available at www.wellsense.org; OR

   e. For a WellSense Medicare Advantage HMO member, reference the Member Handbook in effect at the time of the prior authorization review available at www.WellSense.org/Medicare.

4. Written clinical review criteria used to determine medical necessity of the requested service, including internally developed criteria specified in Plan medical policies and Plan pharmacy policies, InterQual® criteria utilized by the Plan, and clinical guidelines established by delegated management partners, as documented in the Plan's *Clinical Review Criteria* administrative policy, policy number 3.201. There are separate Plan medical policies that address the treatment of certain conditions or procedures that supersede this policy. Reference the individual (and applicable) clinical review criteria for ANY of the services listed in items a through g:

   a. Breast reconstruction; OR

   b. Breast reduction surgery; OR

c. Gender affirmation surgeries; OR

d. Gynecomastia surgery; OR

e. Mastopexy; OR

f. Panniculectomy and redundant skin surgery; OR

g. Temporomandibular joint disorder treatment.

5. Treatment for HIV-associated Lipodystrophy:

a. Criteria for the Treatment of HIV-associated Lipodystrophy for BMC HealthNet Plan Members:

In accordance with Massachusetts state-mandated benefits, the Plan covers medically necessary treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome for a BMC HealthNet Plan member (i.e., Massachusetts resident enrolled in the Plan's MassHealth, Qualified Health Plans, or Senior Care Options product). Review the *Gynecomastia Surgery* medical policy, policy number OCA 3.48, rather than this policy for medical necessity criteria for gynecomastia surgery (including but NOT limited to the surgical treatment for gynecomastia to reduce HIV-associated lipohypertrophy of the chest). For other surgical treatments for HIV-associated lipodystrophy (including reconstructive surgery such as suction-assisted lipectomy or other restorative procedure) or dermal fillers or injections for the treatment of facial lipoatrophy syndrome, ALL of the criteria in items (1) through (4) must be met:

(1) The BMC HealthNet Plan member has a diagnosis of HIV , including HIV-associated facial lipoatrophy syndrome when dermal filler injections or fillers are requested; AND

(2) Conservative treatment and pharmacotherapy have failed to treat the condition or are not appropriate for the member's condition, as determined by the treating provider;∞ AND

(3) The member's HIV-associated lipodystrophy syndrome has caused disturbances of body composition and the surgical treatment (for the treatment of HIV-associated lipodystrophy syndrome) or dermal fillers or injections (for the treatment of HIV-associated facial lipoatrophy syndrome) is medically necessary to treat the member's HIV-associated lipodystrophy and not solely a cosmetic procedure to enhance the member's appearance; AND

(4) The requested treatment meets ANY of following criteria listed in item (a) or item (b):

(a) Dermal fillers or injections (for the treatment of facial lipoatrophy syndrome) is expected to correct or repair the disturbance(s) of body composition caused by HIV-associated lipodystrophy syndrome; AND/OR

(b) Surgical treatment (e.g., liposuction/suction assisted lipectomy, autologous fat grafts, reconstructive breast procedures) is expected to correct or repair the disturbance(s) of body composition caused by HIV-associated lipodystrophy syndrome; OR

Note: For a BMC HealthNet Plan member, applicable criteria and product-specific definitions for cosmetic, reconstructive, and restorative services included in this policy (rather than criteria for HIV-associated lipodystrophy) will be used to determine the medical necessity of the requested treatment of lipodystrophy when it is NOT associated with HIV; the member's benefit coverage guidelines available at www.bmchp.org. For pharmacotherapy, see the Plan's applicable pharmacy policies available at www.bmchp.org for prior authorization guidelines and medical necessity criteria for the BMC HealthNet Plan covered drug list (categorized by medical drug name), including but not limited to the Plan's *Egrifta®* pharmacy policy, policy number 9.032.

b. Criteria for the Treatment of HIV-associated Lipodystrophy for WellSense New Hampshire Medicaid Members:

Applicable criteria and product-specific definitions for cosmetic, reconstructive, and restorative services included in this policy will be used to determine the medical necessity of the requested treatment of HIV-associated lipodystrophy according to the member's benefit coverage guidelines available at www.wellsense.org. For pharmacotherapy, see the Plan's applicable pharmacy policies available at www.wellsense.org for prior authorization guidelines and medical necessity criteria for the WellSense New Hampshire Medicaid covered drug list (categorized by medical drug name), including but not limited to the Plan's *Egrifta®* pharmacy policy, policy number 9.032.

Limitations and Exclusions

Cosmetic services (including devices, drugs, procedures, surgeries, and/or treatments) are considered NOT medically necessary by the Plan due to limited evidence documenting the clinical utility of treatment.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local

coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. Verify CMS guidelines in effect on the date of the prior authorization request that are appropriate for the service and indication for treatment. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Product-Specific Definitions

1. **MassHealth ACO and MassHealth MCO Contract Definitions:**

   Except as otherwise noted, cosmetic services are not covered under MassHealth and as such are not covered by the Plan.

   a. **Cosmetic Surgery:** Cosmetic surgery, **except** as determined by the contractor to be necessary for ANY of the following indications, as specified below in items (1) through (4):

      (1) Correction or repair of damage following an injury or illness which occurred while a member (as defined below); OR

      (2) Mammoplasty following a mastectomy which took place while a member (as defined below); OR

      (3) Repair of a congenital deformity; OR

      (4) Any other medical necessity as determined by the contractor

   b. **Enrollee**: A member enrolled in BMC HealthNet Plan (ACO or MCO) either by choice or assignment by Executive Office of Health and Human Services (EOHHS)

   c. **Member:** A person determined by EOHHS to be eligible for MassHealth

2. **Qualified Health Plan/ConnectorCare/Employer Choice Direct Product Definitions**:

   a. **Cosmetic Services/Cosmetic Surgery**: These are services given solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat your mental condition. Examples of **non-covered** services include but are not limited to ANY of the following, as specified below in items (1) through (7):

      (1) Abdominal liposuction or suction assisted lipectomy of the abdomen; OR

      (2) Abdominoplasty, partial abdominoplasty; OR

(3) Blepharoplasty, unless it is medically necessary to prevent vision occlusion;⌂ OR
Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of blepharoplasty for the treatment of gender dysphoria.

(4) Rhytidectomy (facelift surgery);◊ OR

Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of rhytidectomy for the treatment of gender dysphoria.

(5) Injection of collagen or other bulking agents to enhance appearance; OR

(6) Repair of diastasis recti; OR

(7) Thigh, leg, hip or buttock lifting procedures

b. **Reconstructive Surgery and Procedures:** The Plan covers medically necessary reconstructive surgery and procedures. These are **covered** only when the services are required to relieve pain or to improve or restore bodily function that is impaired as a result of ANY of the following, as specified below in items (1) through (4):

(1) Accidental injury; OR

(2) A birth defect; OR

(3) A covered surgical procedure; OR

(4) Disease

3. **Definitions for WellSense New Hampshire Medicaid Product:**

Cosmetic Services/Cosmetic Surgery: These are services given or procedures performed **solely** for the purpose of changing or improving a member's appearance whether or not these services are meant to make a member feel better about him/herself or treat a member's mental condition, except when required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member. Examples of **excluded** services (when these services are performed solely for the purpose of changing or improving a member's appearance and therefore are cosmetic) include but are not limited to any of the following treatments listed in items a through q:

a. Abdominoplasty, abdominal liposuction, suction assisted lipectomy of the abdomen, mini abdominoplasty, repair of diastasis recti, and/or panniculectomy for back or neck pain and as an adjunct to other procedures; OR

b. Acne related services, such as the removal of acne cysts or injections to raise acne scars; OR

c. Blepharoplasty, unless medically necessary to prevent vision occlusion; OR

   Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of blepharoplasty for the treatment of gender dysphoria.

d. Body piercing; OR

e. Brachioplasty; OR

f. Dermabrasion or other procedures to plane the skin; OR

g. Electrolysis; OR

   Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of hair removal on a skin graft to be used for genital gender affirmation surgery.

h. Rhytidectomy (facelift surgery); OR

Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of rhytidectomy for the treatment of gender dysphoria.

i. Hair removal, hair transplants, or hair restoration; OR

Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of hair removal on a skin graft to be used for genital gender affirmation surgery.

j. Injection of collagen or other bulking agents to enhance appearance; or thigh, leg, hip or buttock lift procedures; OR

k. Liposuction (unless specified otherwise as medically necessary in this policy or another applicable Plan medical policy); OR

l. Removal or destruction of skin tags solely for the purpose of changing or improving a member's appearance; OR

m. Reversal of inverted nipples; OR

n. Rhinoplasty, except as part of a medically necessary reconstructive surgery; OR

Note: A service may be determined to be reconstructive and restorative (rather than cosmetic) when the indication for treatment meets the applicable clinical review criteria included in a Plan medical policy, Plan-adopted InterQual© criteria, or consistent with the definition and criteria for reconstructive and restorative services when service-specific criteria have not been established. The Plan utilizes clinical review criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, to determine the medical necessity of blepharoplasty for the treatment of gender dysphoria.

o. Tattooing or reversal of tattooing except when needed as a result of breast cancer; OR

p. Treatment of melasma; OR

q. Treatment of spider veins

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 05/08/07: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 05/24/07: Utilization Management Committee (UMC) 06/12/07: Quality Improvement Committee (QIC) review and discussion 12/12/07: MPCTAC 12/18/07: UMC review and discussion	06/01/08 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
05/20/08	Changed responsibility section to indicate that the Plan's clinical pharmacists can determine if service requests are considered cosmetic; clarified MassHealth definition of Member and Enrollee.	Version 2	01/22/08: UMC 02/19/08: QIC 05/20/08: UMC 06/19/08: QIC
06/23/09	Changed the name of the policy, added language and definitions for physical functional impairment, reconstructive and restorative services, added procedure grid, changed policy statements, changed definition for cosmetic services. These changes are effective 10/01/09.	10/01/09 Version 3	06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC
06/01/10	Updated references and policy statement.	Version 4	06/30/10: MPCTAC 07/28/10: QIC
07/01/11	Added Commonwealth Choice definitions for cosmetic and reconstructive surgery and updated references.	Version 5	07/22/11: MPCTAC 08/24/11: QIC
07/01/12 and 08/10/12	Moved Purpose section to the beginning of the document, added reference for the Plan's Prior Authorization/ Notification Requirements matrix, explained the use of the prior authorization process to determine the type of service requested (i.e., cosmetic service or reconstructive and restorative service), and added reference to Physician Reviewer. Revised Policy Summary, Definitions, References, Procedure, and Limitations sections for all Plan products (WellSense New Hampshire Medicaid and BMCHP products).	Version 6	07/18/12: MPCTAC 08/22/12: QIC
04/01/13	Review for effective date of 06/01/13. Reformatted policy without revising clinical criteria.	06/01/13 Version 7	04/17/13: MPCTAC 05/16/13: QIC
06/01/14	Review for effective date 08/01/14. Revised Policy Summary and Description of Item or Service sections. Updated Medical Policy Statement section without changing criteria. Added definitions for Qualified Health Plan, Commonwealth Choice/Employer Choice, and WellSense New Hampshire Medicaid products. Removed definitions for Commercial. Updated references.	08/01/14 Version 8	06/18/14: MPCTAC 07/09/14: QIC
06/01/15	Review for effective date 08/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products	08/01/15 Version 9	06/17/15: MPCTAC 07/08/15: QIC

Policy Revisions History			
	because the products are no longer available. Administrative changes made to the Medical Policy Statement and Limitations sections.		
11/01/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Updated Summary and References sections.	01/01/16 Version 10	11/18/15: MPCTAC 12/09/15: QIC
06/01/16	Review for effective date 08/01/16. Updated Definitions section. Administrative change made to the Medical Policy Statement section.	08/01/16 Version 11	06/15/16: MPCTAC 07/13/16: QIC
04/01/17	Review for effective date 07/08/17. Revised criteria in the Medical Policy Statement section. Updated Summary, Definitions, References, and References to Applicable Laws and Regulations. Added Clinical Background Information and Reference to Applicable Laws and Regulations sections.	07/08/17 Version 12	04/19/17: MPCTAC
07/01/17	Review for effective date 08/01/17. Administrative changes made to the Policy Summary and Other Applicable Policies sections.	08/01/17 Version 13	07/19/17: MPCTAC
08/31/17	Updated the Product Applicability, Definitions, and References sections to incorporate the Accountable Care Organization (ACO).	08/31/17 Version 14	08/31/17: MPCTAC (electronic vote)
02/01/18	Review for effective date 03/01/18. Administrative changes made to the Product-Specific Definitions (for WellSense New Hampshire Medicaid product) and Other Applicable Policies sections.	03/01/18 Version 15	02/21/18: MPCTAC
06/01/18	Review for effective date 07/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, References, and Other Applicable Policies sections.	07/01/18 Version 16	06/20/18: MPCTAC
06/01/19	Review for effective date 07/01/19. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	07/01/19 Version 17	06/19/19: MPCTAC
01/01/20	Review for effective date 02/01/20. Administrative changes made to the Medical Policy Statement and Reference to Applicable Laws and Regulations sections.	02/01/20 Version 18	01/15/20: MPCTAC
06/01/20	Review for effective date 07/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	07/01/20 Version 19	06/17/20: MPCTAC
08/01/21	Review for effective date 09/01/21. Updated the Description of Item or Service, Definitions, and References sections. Administrative changes made to the Medical Policy Statement and Limitations sections to clarify current medical policy guidelines.	09/01/21 Version 20	08/13/21: MPCTAC (electronic vote)

Policy Revisions History			
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and References sections.	12/01/21 Version 21	11/17/21: MPCTAC

Next Review Date

06/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: [+]

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.