Medical Policy

Cosmetic, Reconstructive, and Restorative Services

Policy Number: OCA 3.69
Version Number: 12
Version Effective Date: 07/08/17

Product Applicability

<table>
<thead>
<tr>
<th>All Plan Products</th>
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</thead>
<tbody>
<tr>
<td>New Hampshire Medicaid</td>
</tr>
<tr>
<td>NH Health Protection Program</td>
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<tr>
<td>Massachusetts Medicaid (MassHealth)</td>
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<tr>
<td>Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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<tr>
<td>Senior Care Options ◊</td>
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<td>Boston Medical Center HealthNet Plan</td>
</tr>
<tr>
<td>MassHealth</td>
</tr>
<tr>
<td>Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
</tr>
<tr>
<td>Senior Care Options ◊</td>
</tr>
</tbody>
</table>

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

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. Review the Plan’s Prior Authorization/Notification Requirements matrix for a list of services that require prior authorization; in addition, review the Plan’s Prior Authorization CPT/HCPCS Code Look-up Tools for the prior authorization requirement for each of the service’s applicable, industry-standard...
Cosmetic, Reconstructive, and Restorative Services

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 Well Sense Health Plan. See Plan policy, Medically Necessary, policy number OCA 3.14, for the product-specific definitions of medically necessary treatment. Review the product-specific definition of experimental or investigational treatment in the Experimental and Investigational Treatment policy, policy number OCA 3.12. The Plan’s Clinical Criteria policy, policy number OCA 3.201, includes product-specific definitions for clinical review criteria. The Plan’s New Technology 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 Clinical Trials policy, policy number OCA 3.192, if applicable to the requested service.

**Description of Item or Service**

The following 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.

<table>
<thead>
<tr>
<th>Question 1: Is there a physical functional impairment or is pain present?</th>
<th>Question 2: Does the condition meet the definition of a reconstructive and restorative service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category for Question 1</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulation</td>
<td></td>
</tr>
<tr>
<td>Communication, speech</td>
<td></td>
</tr>
<tr>
<td>Nutrition, swallowing</td>
<td></td>
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<tr>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>Respiration, airway, control of secretions</td>
<td></td>
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<tr>
<td>Skin integrity or function</td>
<td></td>
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<tr>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

Cosmetic, Reconstructive, and Restorative Services

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<table>
<thead>
<tr>
<th>Question 3. Can the proposed service be reasonably expected to improve the physical functional impairment or relieve the pain?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Category for Question 3</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Note: No physical functional impairment is required for post-mastectomy services

**Medical Policy Statement**

Review the Plan’s *Prior Authorization/Notification Requirements* matrix for a list of services that require prior authorization; in addition, review the Plan’s *Prior Authorization CPT/HCPCS Code Look-up Tools* for the prior authorization requirement for each of the service’s applicable, industry-standard billing code. 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 Medical Officer, to determine if the requested services are cosmetic, restorative, or reconstructive.

1. **Cosmetic services** (including devices, drugs, procedures, and surgery) are considered not medically necessary by the Plan. Examples of cosmetic services include but are not limited to ANY of the following, as specified below in items a through c:
   a. Ear piercing; OR
   b. Rhytidectomy (facelift procedures); OR
   c. Treatment of keloid scars.

2. **Reconstructive and restorative services** (as specified in the Definitions section of this policy) for eligible members will be considered medically necessary and therefore covered by the Plan when BOTH of the following criteria are met, as specified below in items a and b:
   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 ONE (1) of the following applicable documents for the Plan member as specified below in items a through d (and the definitions documented in the Product-Specific Definitions** section of this policy):

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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 Well Sense Health Plan member, reference the Well Sense Member Handbook in effect at the time of the prior authorization review available at [www.wellsense.org](#).

4. There are separate medical policies that address the treatment of certain specific conditions or procedures that supersede this policy. Medical policies are available at [www.bmchp.org](#) for BMC HealthNet Plan members and at [www.wellsense.org](#) for Well Sense Health Plan members. Please reference the individual (and applicable) medical criteria for ANY of the following services, as specified below in items a through h:

a. Bariatric surgery; OR

b. Breast reconstruction; OR

c. Breast reduction mammoplasty; OR

d. Gender reassignment surgery; OR

e. Gynecomastia surgery; OR

f. Mastopexy; OR

g. Panniculectomy and redundant skin surgery; OR

h. 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 or dermal filler injections for the treatment of facial lipoatrophy syndrome, ALL of the following criteria must be met, as specified below in items (1) through (4),

(1) The BMC HealthNet Plan member has a diagnosis of HIV or AIDS with HIV-associated lipodystrophy syndrome (including HIV-associated facial lipoatrophy syndrome when dermal filler injections 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

For pharmacotherapy, see the Plan’s applicable pharmacy policies available at [www.bmchp.org](http://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.

(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 filler 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 at least ONE of the following criteria, as specified below in item (a) and/or item (b):

(a) Dermal filler 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

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(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 Well Sense Health Plan Members:

For a Well Sense Health Plan member, 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 Well Sense Health Plan covered drug list (categorized by medical drug name), including but not limited to the Plan’s Egrifta® pharmacy policy, policy number 9.032.

Definitions:

Cosmetic Services: Those services that are performed for the primary purpose of altering or improving physical appearance and that do not constitute reconstructive and restorative services (as defined below). Services that meet the definition of reconstructive and restorative services are not considered cosmetic.

HIV-associated Lipodystrophy: Abnormal fat accumulation (lipohypertrophy), localized loss of fat tissue (lipoatrophy), or a combination of both that are associated with metabolic complications (such as dyslipidemia, glucose intolerance, and insulin resistance) and contribute to HIV-related morbidity and mortality through increased cardiovascular and cerebrovascular disease risk. The syndrome occurs in HIV-infected patients treated with antiretroviral medications (e.g., protease inhibitors and nucleoside reverse transcriptase inhibitors). HIV may be a causal factor for lipodystrophy by interfering with way the body processes adipose tissue. Treatment for HIV-associated lipodystrophy may include conservative treatment (diet modification and exercise), pharmacotherapy, or surgical intervention.
when conservative treatment and drug therapy are not effective. The magnitude of fat loss determines the severity of metabolic complications and associated treatment plan.

**Lipodystrophy:** A medical condition resulting in abnormal fat accumulation (lipohypertrophy), localized loss of fat tissue (lipoatrophy), or a combination of both with metabolic complications (such as dyslipidemia, glucose intolerance, and insulin resistance). With lipoatrophy, there is selective, subcutaneous fat loss (either partial or near total absence of adipose tissue) from various regions of the body, generally occurring in the limbs, face, and/or buttocks. Lipohypertrophy (fat accumulation), when present, most commonly occurs in the abdomen, dorsocervical area (developing fat pad enlargement known as buffalo hump), and the breast/chest. In addition, lipomas may develop in other parts of the body. A disruption in the total amount and distribution of adipose tissue (as an active endocrine organ) contribute to metabolic abnormalities that alter hormone levels secreted by adipose tissue. The magnitude of fat loss determines the severity of metabolic complications and may result in dyslipidemia and abnormal glucose metabolism (predisposing the patient to cardiovascular disease and diabetes mellitus). The physical changes associated with the lipodystrophy syndrome can be divided into three (3) major types: lipoatrophy or fat wasting; lipohypertrophy or fat accumulation; and mixed forms with atrophy and hypertrophy coexisting in different body regions. Men tend to experience lipoatrophy and women are more likely to have lipohypertrophy. Withdrawal of antiretroviral therapy and therapeutic strategies do not achieve substantial improvements and may not be medically appropriate. Two major types of lipodystrophies are inherited (familial or genetic lipodystrophies) or secondary to a medical condition or drug treatment (e.g., HIV-associated lipodystrophy).

**Physical Functional Impairment:** A physical condition in which the normal or proper action of a body part or organ is damaged. This includes but is not limited to problems with ambulation, speech and communication, respiration and control of secretions, protection of airway, swallowing, nutrition, vision, or the alteration of skin function (e.g., some dermatologic conditions such as pemphigus that impair the fluid balance of the skin). A physical functional impairment does not include an individual’s emotional well-being or mental health.

**Reconstructive and Restorative Services:** (a) Those services that are performed for the primary purpose of improving, repairing, restoring or correcting a physical functional impairment, or relieving pain, resulting from ANY of the following: accidental traumatic injury, post-therapeutic intervention (e.g., radiation or chemotherapy), birth abnormality, congenital defect, disease process, and/or anatomic variants; or (b) post-mastectomy services for eligible members.

**Product-Specific Definitions:**

1. **MassHealth Contract Definitions:**

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

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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 (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

4. Facelift surgery or rhytidectomy; OR

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

6. Repair of diastasis recti; OR

7. Thigh, leg, hip or buttock lift procedures

b. **Reconstructive Surgery and Procedures**: The Plan covers medically necessary reconstructive surgery and procedures. These are covered only when the services are

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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 Well Sense Health Plan Products:

**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 include but are not limited to the following, as specified below in items a through p:

a. Abdominoplasty; abdominal liposuction or suction assisted lipectomy of the abdomen; mini abdominoplasty; repair of diastasis recti; 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

d. Body piercing; OR

e. Brachioplasty; OR

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

g. Facelift surgery or rhytidectomy; OR

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

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

j. Liposuction; OR
k. Removal or destruction of skin tags; OR

l. Reversal of inverted nipples; OR

m. Rhinoplasty (except as part of a medically necessary reconstructive surgery); OR

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

o. Treatment of melasma; OR

p. Treatment of spider veins

**Clinical Background Information**

At the time of the Plan’s most recent policy review, no national coverage determination (NCD) was found for cosmetic, reconstructive, and restorative services from the Centers for Medicare & Medicaid Services (CMS). A local coverage determination (LCD), Cosmetic and Reconstructive Surgery (L4698), is available for review. CMS guidelines for the medically necessary treatment of lipodystrophy only include dermal injections for the treatment of facial lipodystrophy syndrome (LDS) using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose with HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to the patient’s depression. Determine the applicable CMS criteria in effect for the requested service in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member.

**References**


Contract between the Commonwealth Health Insurance Connector Authority and Plan.

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Contract between the Massachusetts Executive Office of Health and Human Services (EOHHS) and Plan.

Contract between the New Hampshire Department of Health and Human Services and Plan.


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Senior Care Options Contract between the Massachusetts Executive Office of Health and Human Services (EOHHS) and Plan and Medicare Advantage Special Needs Plan Contract between the Centers for Medicare & Medicaid Services (CMS) and the Plan.


<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Original Policy Approved by</th>
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</thead>
<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>06/01/08 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)</td>
<td>MPCTAC, Quality Improvement Committee (QIC), and Utilization Management Committee (UMC)</td>
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<tr>
<td>Internal Approval:</td>
<td>05/08/07: MPCTC</td>
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<td>05/24/07: UMC</td>
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<td>06/12/07: QIC review and discussion</td>
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<td>12/12/07: MPCTAC</td>
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<td></td>
<td>12/18/07: UMC review and discussion</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Product(s): 01/01/13
*Effective Date for the Senior Care Options Product(s): 01/01/16

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### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/20/08</td>
<td>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.</td>
<td>Version 2</td>
<td>01/22/08: UMC 02/19/08: QIC 05/20/08: UMC 06/19/08: QIC</td>
</tr>
<tr>
<td>06/23/09</td>
<td>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.</td>
<td>10/01/09 Version 3</td>
<td>06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC</td>
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<tr>
<td>06/01/10</td>
<td>Updated references and policy statement.</td>
<td>Version 4</td>
<td>06/30/10: MPCTAC 07/28/10: QIC</td>
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<tr>
<td>07/01/11</td>
<td>Added Commonwealth Choice definitions for cosmetic and reconstructive surgery and updated references.</td>
<td>Version 5</td>
<td>07/22/11: MPCTAC 08/24/11: QIC</td>
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<tr>
<td>07/01/12</td>
<td>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 Summary, revised Definitions, updated references, revised Policy Statement, Procedure and Limitations for all Plan products (Well Sense and BMCHP products).</td>
<td>Version 6</td>
<td>07/18/12: MPCTAC 08/22/12: QIC</td>
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<tr>
<td>04/01/13</td>
<td>Review for effective date of 06/01/13. Reformatted policy without revising clinical criteria.</td>
<td>06/01/13 Version 7</td>
<td>04/17/13: MPCTAC 05/16/13: QIC</td>
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<tr>
<td>06/01/14</td>
<td>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 Well Sense Health Plan products. Removed definitions for Commercial. Updated references.</td>
<td>08/01/14 Version 8</td>
<td>06/18/14: MPCTAC 07/09/14: QIC</td>
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<td>06/01/15</td>
<td>Review for effective date 08/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products.</td>
<td>08/01/15 Version 9</td>
<td>06/17/15: MPCTAC 07/08/15: QIC</td>
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**Policy Revisions History**

<table>
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<th>Description</th>
<th>Effective Date</th>
<th>Revision Date</th>
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<tr>
<td>11/01/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Updated Summary and References sections.</td>
<td>01/01/16</td>
<td>11/18/15: MPCTAC</td>
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<tr>
<td>06/01/16</td>
<td>Review for effective date 08/01/16. Updated Definitions section. Administrative change made to the Medical Policy Statement section.</td>
<td>08/01/16</td>
<td>06/15/16: MPCTAC</td>
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<tr>
<td>06/01/17</td>
<td>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.</td>
<td>07/08/17</td>
<td>04/19/17: MPCTAC</td>
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**Last Review Date**

04/01/17

**Next Review Date**

06/01/17

**Authorizing Entity**

MPCTAC

**Other Applicable Policies**

Administrative Policy – *Clinical Criteria*, policy number OCA 3.201
Administrative Policy – *New Technology*, policy number OCA 3.13
Medical Policy – *Bariatric Surgery*, policy number OCA 3.49
Medical Policy – *Breast Reduction Mammaplasty*, policy number OCA 3.44
Medical Policy – *Clinical Trials*, policy number OCA 3.192
Medical Policy – *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
Medical Policy – *Experimental and Investigational*, policy number OCA 3.12
Medical Policy – *Gynecomastia Surgery*, policy number OCA 3.48
Medical Policy – *Mastopexy*, policy number OCA 3.717
Medical Policy – *Medically Necessary*, policy number OCA 3.14
Medical Policy – *Panniculectomy and Related Redundant Skin Surgery*, policy number OCA 3.722
Medical Policy – *Temporomandibular Joint Disorder Treatment*, policy number OCA 3.968

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Pharmacy Policy – Egrifta®, policy number 9.032

Reference to Applicable Laws and Regulations


M.G.L. Chapter 233: An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment.


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.