Medical Policy

Cosmetic, Reconstructive, and Restorative Services

Policy Number: OCA 3.69
Version Number: 11
Version Effective Date: 08/01/16

Product Applicability

All Plan+ Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options ◊

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). Review the Plan’s Prior Authorization/Notification Requirements matrix for a list of services that require prior authorization. It will be determined during the Plan’s prior authorization process if the requested service is considered a cosmetic service or a reconstructive and restorative service.
The prior authorization matrix and Plan medical policies and reimbursement policies are available at www.bmchp.org for BMC HealthNet Plan members and www.wellsense.org for Well Sense Health Plan members. 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>
</tr>
<tr>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>Respiration, airway, control of secretions</td>
<td></td>
</tr>
<tr>
<td>Skin integrity or function</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

Question 3. Can the proposed service be reasonably expected to improve the physical functional impairment or relieve the pain?

| Category for Question 3 | Yes | No |
| --- | --- |

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

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):
   
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](http://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](http://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](http://www.bmchp.org); OR  

---

* 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.
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.

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.

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.

   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

*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.*
(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 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

References

Contract between the Commonwealth Health Insurance Connector Authority and Plan.

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.

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.

*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.
<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
</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) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, QIC, and Utilization Management Committee (UMC)</td>
</tr>
<tr>
<td>Internal Approval: 05/08/07: MPCTC 05/24/07: UMC 06/12/07: QIC review and discussion 12/12/07: MPCTAC 12/18/07: UMC review and discussion</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

### 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>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>07/01/12 and 08/10/12</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 services).</td>
<td>Version 6</td>
<td>07/18/12: MPCTAC 08/22/12: QIC</td>
</tr>
</tbody>
</table>

* 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.
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Version</th>
<th>Reviewing Body</th>
</tr>
</thead>
<tbody>
<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</td>
<td>04/17/13: MPCTAC</td>
</tr>
<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</td>
<td>06/18/14: MPCTAC</td>
</tr>
<tr>
<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 because the products are no longer available. Administrative changes made to the Medical Policy Statement and Limitations sections.</td>
<td>08/01/15</td>
<td>06/17/15: MPCTAC</td>
</tr>
<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>
</tr>
<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>
</tr>
</tbody>
</table>

**Last Review Date**
06/01/16

**Next Review Date**
06/01/17

**Authorizing Entity**
QIC
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 Mamoplasty, 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

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.

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.