PROVIDER POLICIES & PROCEDURES

RECONSTRUCTIVE SURGERY

The purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for reconstructive surgery. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Reconstructive surgery is performed to restore or improve function associated with abnormalities to the face or body, caused by birth defects, injury, or disease (including reconstructive surgery status-post mastectomy).

HUSKY Health primarily uses Change Healthcare's InterQual® Criteria when reviewing prior authorization requests for reconstructive surgery. HUSKY Health will use this policy to review requests for reconstructive surgery for which InterQual Criteria are not available.

The following procedures are reviewed using **InterQual® Criteria** along with the DSS definition of Medical Necessity:

- Blepharoplasty
- Breast reduction (reduction mammoplasty)
- Excision of tumor or soft tissue of face or scalp (subcutaneous tissue)
- Genioplasty for the treatment of obstructive sleep apnea
- Gynecomastia surgery
- Panniculectomy
- Pectus carinatum and excavatum repair
- Rhinoplasty
- Septoplasty or submucous resection
- Tissue Transfer (Flap) Repair for scar revision

CLINICAL GUIDELINE

Coverage guidelines for reconstructive surgery are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Craniofacial

External Ear

External ear reconstruction (CPT code 69300) may be considered medically necessary when the ears are absent or deformed from a congenital defect, trauma, or disease and when the surgery is performed to address a functional deficit including:

A. To improve hearing by directing sound in the ear canal;
B. To allow for the use of a conventional air conduction hearing aid; or
C. To allow for the use of eyewear for the correction of vision loss.

Craniofacial Tumors

Excision of a tumor, or soft tissue of the face or scalp that is subfascial, e.g., subgaleal or intramuscular (CPT codes 21013-21014) may be considered medically necessary when:

A. The tumor is causing pain or bleeding;
B. The tumor is obstructing an orifice;
C. The tumor is restricting vision;
D. The tumor is in an anatomical region subject to recurrent trauma;
E. The tumor is impairing the individual's ability to perform activities of daily living or otherwise preventing normal function of a body part;
F. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the lesion appearance; or
G. A prior biopsy suggests or is indicative of a malignant lesion.

Note: Submitted documentation must indicate the specific location and size of the tumor along with the associated symptoms. The documentation should also include any relevant imaging or pathology findings.

Reconstruction of a benign tumor of the cranial bones (CPT code 21181) may be considered medically necessary when a physical and/or physiological abnormality is causing a recurrent or persistent functional impairment that requires correction.

Orbital/Periorbital bones

Reconstruction of the orbit with extracranial osteotomies and with bone grafts, e.g., micro-ophthalmia (CPT code 21256) may be considered medically necessary when:

A. The micro-ophthalmia is complex and is associated with other eye abnormalities (i.e., cataracts, ptosis, coloboma);
B. There is limited visual acuity;
C. There is severe vision loss; or
D. There is blindness.

Reconstruction of periorbital bones for orbital hypertelorism (CPT codes 21260, 21261, and 21267) may be considered medically necessary when a physical and/or physiological abnormality is present, and correction is needed to improve or restore a physiological function.

Septum

Septal and other intranasal dermatoplasty (CPT code 30620) may be considered medically necessary when one or more of the following scenarios apply:

A. Symptoms of nasal obstruction are present and other treatable causes of obstruction, e.g., nasal polyps, have been ruled out;
B. There is persistent or recurrent epistaxis; or
C. There is chronic sinusitis or recurrent acute sinusitis;

AND

D. A trial of conservative management (i.e., topical nasal corticosteroids, decongestants, antibiotics either trialed alone or in combination) has been attempted and failed.

Autologous Bone Graft

An autologous bone graft (CPT code 20900) may be considered medically necessary when used alone or in combination with another graft material or substitute and the bone graft will:

A. Enhance and promote healing of bone, e.g., a delayed fracture union;
B. Bridge major bone defects; or
C. Fill cavities created by tumor removal, cysts, or other defects caused by diseases.

Breast Reconstructive Surgery

The Women's Health and Cancer Rights Act of 1998 requires that in patients with breast cancer or a history of breast cancer, all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy including lymphedema are considered medically necessary. Therefore, certain procedures typically considered cosmetic in nature e.g., **breast augmentation, breast implants, nipple prosthetics, mastopexy, tattooing** would be considered reconstructive and therefore medically necessary in this instance.

Gender Affirmation

Certain procedures typically considered cosmetic in nature and therefore not medically necessary may be considered medically necessary when related to gender affirmation. (Reference: HUSKY Health Gender Affirmation Surgery policy)

NOTE: EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization for reconstructive surgery is required. Requests for coverage of reconstructive surgery will be reviewed in accordance with procedures in place for reviewing requests for outpatient surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for reconstructive surgery:

1. Fully completed authorization request via on-line web portal;
2. Clinical documentation as outlined in the *Clinical Guideline* section from the requesting physician, APRN, or PA supporting the medical necessity of the requested procedure (note: photographs may be requested as needed for medical necessity determination); and
3. Other information as requested.

EFFECTIVE DATE
This Policy is effective for prior authorization requests of reconstructive surgery for individuals covered under the HUSKY Health Program beginning November 1, 2021.

LIMITATIONS
N/A

CODES

Reviewed Using Policy

Code	Description
11922	Tattooing; intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm
20900	Bone graft, any donor area; minor or small (e.g., dowel or button)
21013	Excision, tumor, soft tissue of face or scalp, subfascial (e.g., subgaleal, intramuscular); less than 2 cm
21014	Excision, tumor, soft tissue of face or scalp, subfascial (e.g., subgaleal, intramuscular); 2 cm or greater
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia) extracranial
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
30620	Septal or other intranasal dermatoplasty
69300	Otoplasty, protruding ear, with or without ear reduction
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each

Reviewed Using InterQual Criteria

Code	Description
11920	Tattooing; intradermal introduction of insoluble opaque pigments to correct color defects of skin
11921	Tattooing; intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15830	Panniculectomy
19300	Removal of breast tissue for gynecomastia
19318	Breast reduction (reduction mammoplasty)
19325	Breast augmentation with implant
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast complete, including removal of all intracapsular

	contents
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater
21120	Genioplasty augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty sliding osteotomy, single piece
21122	Genioplasty sliding osteotomies, 2 or more osteotomies
21123	Genioplasty sliding, augmentation with interpositional bone grafts
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative

service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

RESOURCES AND REFERENCES:

- American Society of Plastic Surgeons (ASPS). Cosmetic, reconstructive, and plastic surgery descriptions. Accessed June 4, 2021.
- UptoDate. Congenital Anomalies of the Ear. Last updated November 11, 2019.
- UptoDate. Overview of Benign Lesions of the Skin. Last updated February 10, 2023.
- Wisconsin Physicians Service Insurance Corporation. Local Coverage Determination: Removal of Benign Skin Lesions (L35498). Revised 10/31/2019.
- Women's Health and Cancer Rights Act of 1998. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra. Accessed June 2, 2021.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	September 2021	Approved at the June 23, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on September 20, 2021. Approved by DSS on September 30, 2021.
Reviewed	September 2022	Reviewed and approved without changes at the July 13, 2022 CHNCT Medical Reviewer meeting. Reviewed and approved without changes by the CHNCT Clinical Quality Subcommittee on September 19, 2022. Approved by DSS on September 28, 2022.
Updated	March 2023	Updates to Clinical Guideline section. Added criteria for excision of tumor, soft tissue of face or scalp. Updates to References section. Changes approved at the March 8, 2023, CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Updated	June 2023	Updated Clinical Guideline section regarding nature of cosmetic procedures, changed to "Cosmetic surgery is NOT covered for HUSKY Health Program members. The following procedures are considered cosmetic as their primary purpose is typically to preserve or improve appearance. Under unique circumstances, these procedures may be considered medically necessary based on an assessment of the individual's specific medical needs". Change approved at the May 10, 2023 CHNCT Medical Reviewer meeting. Change approved at the CHNCT Clinical Quality Subcommittee on June 19, 2023. Approved by DSS on June 28, 2023.

Updated	June 2024	Introduction section updated to clarify and redefine reconstructive and cosmetic procedures. Introduction section also updated to inform HUSKY Health uses InterQual criteria for certain reconstructive procedures that require prior authorization (PA) and will use this policy to review requests for reconstructive procedures for which InterQual® Criteria are not available. Clinical Guideline section updated to include criteria for all reconstructive procedures that do not have InterQual criteria. The Cosmetic procedure list was updated to include all procedures considered as cosmetic that require PA. Procedure section updated to include clinical documentation from the requesting physician, APRN, or PA and inform photographs may be requested by CHNCT. Code section updated to distinguish reconstructive and cosmetic codes reviewed using the policy and reconstructive and cosmetic codes reviewed using InterQual criteria. Changes approved at the June 12, 2024 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on June 17, 2024. Approved by DSS on June 26, 2024.
Updated	March 2025	Policy updated throughout to remove cosmetic surgery. Policy addresses reconstructive surgery only. Separate policy will address cosmetic surgery. Code section updated to remove codes for cosmetic surgery. Resources and References updated reflect current references. Changes approved at the March 12, 2025 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 17, 2025. Approved by DSS on April 3, 2025.