PROVIDER POLICIES & PROCEDURES

COSMETIC AND 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 cosmetic and 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 treat body parts affected aesthetically or functionally by congenital defects, developmental abnormalities, or trauma. Cosmetic plastic surgery includes surgical and nonsurgical procedures that enhance and reshape structures of the body to improve appearance and confidence.

CLINICAL GUIDELINE

Coverage guidelines for cosmetic and 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:

Reconstructive Surgery

Reconstructive surgery is covered for HUSKY Health Program members when determined to be medically necessary.

I. External ear reconstruction (CPT codes 69310, 69320) may be considered medically necessary when the ears are absent or deformed from 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 eyewear for the correction of vision loss.

   Note: *see below for cosmetic "otoplasty"*

II. Rhytidectomy (CPT codes 15824 -15829) may be considered medically necessary to correct a functional impairment as a result of a disease state (i.e., severe burns, facial paralysis) that cannot be corrected without surgery (*see below for cosmetic*).

III. Skin tag removal (CPT codes 11200-11201) may be considered medically necessary when located in an area of friction with documentation of repeated irritation and bleeding (*see below for cosmetic*).

IV. Tattooing (CPT codes 11920-11922) may be considered medically necessary as part of breast reconstructive surgery post-mastectomy (*see below for cosmetic*).

V. Excision of a tumor, soft tissue of face or scalp (CPT codes 21011-21014) 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 lesion malignancy.

   Note: If the above criteria are not met, the procedure will be considered cosmetic and not medically necessary.

   The documentation submitted 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.

The following procedures may be considered reconstructive and are reviewed using Change HealthCare's InterQual® Criteria along with the DSS definition of Medical Necessity:

- Blepharoplasty
- Breast reduction (reduction mammoplasty)
- Genioplasty
- Gynecomastia surgery
- Panniculectomy
- Pectus carinatum and excavatum repair
- Rhinoplasty
- Scar revision

The following procedure(s)/devices may be considered reconstructive and are reviewed using HUSKY Health Program Medical Policies:

- Orthognathic surgery
- Compressive Orthoses for Correction of Pectus Carinatum and Excavatum
- Cranial Remodeling Devices

Cosmetic Surgery

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:

- Abdominoplasty
- Aesthetic operations on umbilicus

- Body modification repairs or reversal (e.g., repair of stretched earlobes)
- Brachioplasty
- Breast augmentation
- Buttock or thigh lift
- Canthopexy or canthoplasty
- Cheek implant (malar implant/augmentation)
- Deoxycholic acid injection
- Microdermabrasion
- Diastasis recti repair
- Electrolysis
- Excessive/redundant skin removal from limbs and other areas of the body
- Facial bone reduction or enhancement
- Facial rejuvenation/plumping/collagen or fat grafts/injections
- Hairplasty (hair transplant)
- Injectable dermal fillers used to sculpt body contours
- Intense pulsed light laser for skin redness
- Inverted nipple correction
- Labiaplasty
- Laser hair removal
- Laser skin treatment for wrinkling, aging skin, or spider angiomas
- Lip augmentation
- Lipectomy
- Liposuction used for body contouring for alteration of appearance
- Lower body lift
- Mastopexy
- Mesotherapy
- Neck tucks
- Otoplasty for prominent/protruding ears, lop ears, cupped ears, constricted ears to improve physical appearance (*see above for external ear reconstruction*)
- Piercing
- Penis enhancement surgery
- Removal of glabellar frown lines
- Rhytidectomy for aging skin (*see above for reconstructive)*
- Skin tag removal to improve appearance in the absence of a functional impairment (*see above for reconstructive*)
- Surgery for body dysmorphic disorder
- Surgery to correct “moon face”
- Tattooing (*see above for reconstructive*)
- Salabrasion (tattoo removal)
- Torsoplasty (body lift)
- Treatment for skin wrinkles
- Treatment for telangiectasia
- Vaginal rejuvenation procedures

Note:

- **Breast Reconstruction:** 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 implants, 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 supporting the medical necessity of the requested procedure; 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

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. Available at: www.plasticsurgery.org. Accessed June 4, 2021.
- Regulations of Connecticut State Agencies: 17b-262-342 - Goods and Services Not Covered
- 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.

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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.