Benefit Coverage

Covered Benefit for lines of business including:
RiteCare (MED), Substitute Care (SUB), Children with Special Needs (CSN), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Health Benefit Exchange (HBE)
Excluded from Coverage:
Extended Family Planning (EFP)

Medicare Distinction

For INTEGRITY members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable payment policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other available CMS published guidance.

In the absence of an applicable or incomplete NCD, LCD, or other CMS published guidance OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the members' Medicaid benefit.

Description

Plastic Surgery is a branch of surgery concerned with the repair, restoration, or improvement of lost, injured, defective, or misshapen parts of the body chiefly by transfer of tissue.

In the absence of medical necessity, surgery being performed solely to enhance physical appearance is considered "cosmetic," and therefore not covered.

The American Society of Plastic Surgeons defines the following:

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Coverage Determination

Requires Authorization	Prior authorization and review of medical necessity documentation is required. For skin and other criteria please see specific section below. Plastic surgery is considered a clinical option for members when: 1. At least one of the conditions is met from the "**conditions**" list, AND 2. Documentation indicates that conservative measures have been tried and failed

Criteria

Conditions:

- ☐ Repair of severe disfigurement resulting from a disease, an injury, or a non-cosmetic medical procedure.
- ☐ Repair of disfigurement resulting from a congenital anomaly that interferes with function, or is one which causes a gross disfigurement from normal.
- ☐ Breast reconstruction surgery following a mastectomy, including all stages of reconstruction of the breast on which the mastectomy has been performed, as well as surgery and reconstruction of the other breast to produce a symmetrical appearance.
- ☐ Surgery as treatment for scars that cause pain, functional limitation, or are medically symptomatic.
- ☐ Other procedures to relieve problems associated with difficulty in activities of daily living.

Note: Additional criteria may be utilized, including National and community standards of practice.

Skin Criteria – benign skin lesions

Conditions – **at least ONE** of the conditions is met from the list below:

- ☐ The lesion has evidence of inflammation (purulence, edema or erythema) **OR**
- ☐ The lesion is clinically suspicious for malignancy, **OR**
- ☐ Lesion has one of the following conditions: sudden enlargement over one month, bleeding, ulceration, intense itching or pain, **OR**
- ☐ The lesion restricts vision or obstructs a body orifice, **OR**
- ☐ The lesion is in an anatomical position that has been subject to recurrent trauma and there is evidence that such trauma has occurred.

If any of the above conditions is not present, removal of acrochordon (skin tags), nevi, dermatofibromas, sebaceous cysts, seborrheic keratoses, lipomas, pilomatricoma or other benign lesions would be considered cosmetic and not medically necessary.

Please note that prior authorization is **NOT** required for biopsies of any skin lesions considered to be suspicious for malignancy.

Covered Procedures

All current surgical CPT codes other than those determined to be exclusions or not medically necessary upon review of submitted documentation.

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Covered Codes: For information on coding, please reference the Authorization Quick Reference Guide.

Exclusions

Neighborhood does not cover experimental procedures or treatments, cosmetic surgery, rhinoplasty, and revision of scars when the goal is purely cosmetic or when the scar is a result of a non-covered surgery or body piercing. Treatment of scarring which resulted from acne is also not covered, as this is considered cosmetic.

CMP Cross Reference:

Created:	December 2010
Annual Review Month:	April
Review Dates:	12/29/10, 7/1/13, 09/16/14, 3/3/15, 2/18/16, 2/28/17, 2/27/18*, 3/16/22, 3/8/23, 4/10/24
Revision Dates:	10/29/09, 7/16/13, 09/16/14, 3/3/15, 2/18/16, 2/28/17, 2/27/18*, 3/16/22
CMC Review Date:	11/03/04, 11/10/09, 11/09/10, 1/11/11, 1/10/12, 7/16/13, 9/16/14, 3/3/15, 3/01/16, 3/14/17, 3/20/18*, 3/16/22, 3/8/23, 4/10/24
Medical Director Approval Dates:	11/03/04, 11/10/09, 11/09/10, 2/14/11, 2/23/12, 7/18/13, 10/8/14, 3/3/15, 03/01/16, 3/22/17, 4/12/18*, 3/16/22, 3/8/23, 4/10/24
Effective Date:	10/8/14, 3/3/15, 3/14/16, 7/1/16, 3/23/17, 4/12/18*, 3/16/22, 3/8/23, 4/10/24

*Please note that this policy was archived in 2018. It was reinstated in March 2022.

Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.

References:

American Society of Plastic Surgeons. www.plasticsurgery.org. "Recommended Insurance Coverage Criteria for Third Party Payers-various topics." Available from: http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/key-issues/Gynecomastia-Insurance-Coverage.pdf

Centers for Medicare & Medicaid Services. CMS.gov. The Center for Consumer Information & Insurance Oversight. *The Women's Health and Cancer Rights Act*. Available from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

Goldstein, A.. (10/2023). *Overview of benign lesions of the skin*. Available from www.Uptodate.com. http://www.uptodate.com/contents/overview-of-benign-lesions-of-the-skin?source=search_result&search=Search+UpToDateOverview+of+benign+lesions+of+the+skin&selectedTitle=4%7E150