DeanHealthPlan
A member of SSM Health

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Plastic and Reconstructive Surgery MP9022

Covered Service: Yes

Prior Authorization Required: Yes

Additional Information:

American Medical Association (AMA) approved definitions:

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

Reconstructive surgery: Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defect, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function.

Medicare Policy: Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Medicare Cost (Dean Care Gold) and Medicare Supplement (Select) when the service is provided by participating providers. Prior authorization is required if a member has Medicare primary and Dean Health Plan secondary coverage.

BadgerCare Plus Policy: Dean Health Plan covers when BadgerCare Plus also covers the benefit.

Dean Health Plan Medical Policy:

1.0 Plastic surgery or scar revision treatments **require** prior authorization through the Health Services Division and are considered medically necessary when performed to restore body function after injury.

1.1 Fractional ablative laser fenestration **requires** prior authorization through the Health Services Division and is considered medically necessary when **ALL** of the following criteria are met:

1.1.1 Documentation of significant physical functional impairment related to the scar (e.g. limited movement); **AND**

1.1.2 The treatment can be reasonably expected to improve the physical functional impairment; **AND**

1.1.3 The member has tried at least one other scar revision intervention (e.g. silicone gel or sheeting, pressure garments).

1.2 Fractional ablative laser fenestration of burn or traumatic scars is considered not medically necessary when performed in the absence of a significant physical

functional impairment (e.g. when performed to enhance the appearance of the upper layers of skin as a result of acne, acne scars, uneven pigmentation or wrinkles, and other indications).

2.0 Procedures that **do not require** prior authorization and are considered medically necessary when **one or more** of the following conditions are present and clearly documented in the medical record for diagnoses including but not limited to:

- 2.1 Congenital nevus: if > 1 cm in diameter or any sebaceous or atypical nevi with the potential for malignancy
- 2.2 Congenital ear tags if **one or more** of these characteristics are present:
  - 2.2.1 Bleeding
  - 2.2.2 Itching
  - 2.2.3 Pain or evidence of inflammation
  - 2.2.4 Located such that they are subject to recurrent trauma.
- 2.3 Bell's Palsy: if sling is necessary to lift facial muscles
- 2.4 Removal of lesions or warts if **one or more** of the following is documented:
  - 2.4.1 With documentation of one or more of these characteristics: bleeding, itching, pain, or recurrent trauma in an anatomical region
  - 2.4.2 With physical evidence of inflammation (e.g. purulence, edema, erythema)
  - 2.4.3 Obstructing an orifice, or clinically restricting vision
  - 2.4.4 When clinical uncertainty of diagnosis exists, particularly where malignancy is a realistic consideration based on lesion appearance, or prior biopsy
- 2.5 Cleft lip/palate repair professional services at a multidisciplinary Cleft Palate Clinic (e.g. speech pathologist, ENT, plastic surgeons, dental and oral surgeons) that are considered medically necessary include but are not limited to:
  - 2.5.1 Prosthetics which augment surgery or delay eventual surgery for the purposes of covering clefts, fistulas, etc., or assuring feeding in infants.
  - 2.5.2 Palatal expanders which slowly expand the dental arches (during infancy to avoid major surgery later).
  - 2.5.3 Surgical services which may include rhinoplasty performed to correct a nasal deformity due to cleft lip and/or palate.

3.0 Surgery **requires** prior authorization and may be medically necessary to correct the following diagnosis:

- 3.1 Microtia: medically necessary if member must wear spectacles
- 3.2 Gynecomastia: see Medical Policy Breast Surgeries MP9026
- 3.3 Severe rhinophyma

4.0 A panniculectomy **requires** prior authorization through the Health Services Division and may be considered medically necessary to treat skin disease complaints only if there is documentation of **both** of the following:

- 4.1 Six-month history documenting failure of standard non-surgical treatment; **AND**
- 4.2 Confirming consultation with a dermatologist recommending panniculectomy for treatment of refractory skin disease.

5.0 Surgery to correct the following congenital defects **does not** require prior authorization and are considered medically necessary for diagnoses (including but not limited to):

- 5.1 Severe mid-face retrusion
- 5.2 Hemifacial microsomia (Perry-Romberg Disease)
- 5.3 Tubular, severely constricted, or congenital absence of the breast.

6.0 Surgery to correct congenital birth defects and birth abnormalities that compromise normal bodily functions **requires** prior authorization through the Health Services Division with review by a Medical Director and is considered medically necessary for functional repair or restoration of any body part when necessary to achieve normal body functioning. The written referral request must clearly state the purpose of and the functional repair or restoration to be performed.

7.0 Rhinoplasty **requires** prior authorization through the Health Services Division and is considered medically necessary in the following clinical situations:

- 7.1 When it is being performed to correct a nasal deformity due to a congenital defect;
- 7.2 When rhinoplasty is required to relieve nasal airway obstruction.

8.0 Otoplasty **requires prior authorization** through the Health Services Division and is considered medically necessary to

- 8.1 Improve hearing by directing sound in the ear canal when the ears are absent or deformed from trauma, surgery, disease or congenital defect.
- 8.2 Otoplasty to correct prominent, protruding, lop, cupped or constricted ears is considered cosmetic when not medically necessary to improve hearing.

9.0 Procedures that are generally performed to enhance body appearance and are not reconstructive in nature are not medically necessary. The following procedures are examples (not an all-inclusive list):

- 9.1 Abdominoplasty
- 9.2 Body contouring (including liposuction or subcutaneous injection of filling material)
- 9.3 Brow lift
- 9.4 Calf implants
- 9.5 Cheek (malar) implants, nose implants or chin implants
- 9.6 Chemodenervation for wrinkle reduction

9.7 Collagen implants for other than treatment of incontinence

9.8 Correction of flop ears

9.9 Dermabrasion

9.10 Ear of body piercing including complications such as torn ear lobes, allergic reactions

9.11 Electrolysis

9.12 Face lift or neck lift (rhytidectomy)

9.13 Facial bone reduction

9.14 Intense pulsed light laser for facial redness

9.15 Laser hair removal (unless MP9465 Sex Reassignment Surgery criteria are met)

9.16 Liposuction

9.17 Lip reduction or enhancement

9.18 Mastopexy

9.19 Neck Tucks

9.20 Pectoral implants

9.21 Removal of excess or redundant skin

9.22 Removal of extra digits (unless there is a functional deficit)

9.23 Removal of lesions/skin tags

9.24 Scars that are asymptomatic

9.25 Sclerotherapy for spider veins or telangiectasia

9.26 Selective neurectomy of gastrocnemius muscle for correction of calf hypertrophy

9.27 Skin resurfacing (including dermabrasion, chemical peel, or chemical exfoliation)

9.28 Tattooing (unless MP9476 Breast Reconstruction Surgery criteria are met)

9.29 Tattoo removal – salabrasion

9.30 Voice modification surgery (including laryngoplasty, cricothyroid approximation or vocal cord shortening).

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