Harvard Pilgrim Health Care

UMCM Policy
Cosmetic, Reconstructive and Restorative Procedures

Subject: Cosmetic, Reconstructive and Restorative Procedures

Authorization:

Prior authorization is required for specific cosmetic and reconstructive procedures including:

- Breast Surgeries (i.e., Breast Augmentation, Breast Reconstruction, Reduction Mammoplasty, Breast Implant Removal, and Repair of Inverted Nipple): See HPHC Medical Review Criteria for Breast Surgeries
- Eye Procedures (i.e., Brow Ptosis Repair, Lower Blepharoplasty, Upper Blepharoplasty, Upper Blepharoptosis Repair: See HPHC Medical Review Criteria for Reconstructive/Restorative Eye Procedures
- Gynecomastia Surgery: See HPHC Medical Review Criteria for Gynecomastia Surgery
- Nasal Procedures (i.e., Rhinophyma Treatment, Rhinoplasty, Septoplasty): See HPHC Medical Review Criteria for Reconstructive/Restorative Nasal Procedures
- Panniculectomy and Removal of Excess/Redundant Skin: See HPHC Medical Review Criteria for Panniculectomy and Removal of Redundant Skin and Subcutaneous Tissue
- Skin Procedures (i.e., Surgical Scar Revision, Treatment of Hemangiomas and Port Wine Stains): HPHC Medical Review Criteria for Reconstructive/Restorative Skin Procedures
- Transgender Services (i.e. Augmentation mammoplasty, Clitoroplasty, Colovaginoplasty, Facial feminization procedures, Labiaplasty, Orchiectomy, Penectomy, Rhinoplasty, Vaginoplasty, Colpectomy, Hysterectomy, Mastectomy (bilateral), Metoidioplasty, Phalloplasty, Salpingo-oophrectomy, Scrotoplasty with placement of testicular prostheses, Urethroplasty): Medical Review Criteria for Transgender Services

Policy and Coverage Criteria:

Harvard Pilgrim Health Care (HPHC) does not cover cosmetic procedures (i.e., surgery or treatment performed primarily to reshape or improve a patient's appearance); such procedures are generally not considered medically necessary, even when intended to improve an individual's emotional well-being or treat a mental health condition.

- Services required to treat complications of non-covered cosmetic services are covered only when medically necessary in all other respects.

HPHC covers reconstructive procedures (i.e., surgery performed to improve function of a body part damaged or impaired by congenital defect, developmental abnormality, trauma, infection, tumor or disease) that are reasonable and medically necessary to improve or correct a physical functional impairment or remedy ongoing medical complications.

HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members' unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.

- Coverage may include restorative procedures that are medically necessary to approximate a normal facial appearance after accidental injury (e.g., repair of a facial disfigurement following a serious automobile accident).
- For children under age 18 years enrolled through a Massachusetts (MA) employer group, HPHC covers reconstructive procedures that the attending physician or surgeon determines are medically necessary and consequent to the treatment of the cleft lip and/or cleft palate.

Exclusions:

Harvard Pilgrim Health Care (HPHC) considers cosmetic and reconstructive procedures as not medically necessary for all other indications; including but not limited to:

- Ear Procedures:
    - Ear lobe repair of chronic distortion related to ear piercing
    - Ear Piercing
    - Otoplasty (CPT code 69300)
    - Repair of torn ear lobe after wound has healed
    - Total External Ear Reconstruction
- Facial Procedures:
    - Forehead Reduction that is not part of authorized facial feminization surgery for a member with Transgender benefits
    - Genioplasty performed to change the appearance of any portion of the face
    - Malar Augmentation
    - Masseter Reduction
    - Rhytidectomy as a cosmetic service
- Hair Removal (permanent or temporary) by any method
- Hair Restoration or Hair Transplants (e.g., to correct male pattern baldness, age-related hair thinning, baldness (alopecia) due to disease, previous therapy, or congenital scalp disorders

Guidelines:

In accordance with MA Chapter 233 (An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment), HPHC covers treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome for any member enrolled in any HPHC plan delivered, issued or renewed within the commonwealth. Medical record documentation from a treating provider must confirm that the treatment is medically necessary for correcting, repairing or ameliorating the effects of HIV associated lipodystrophy syndrome.

Summary of Changes:

Date	Changes
11/20	Annual review; no changes
12/19	Annual review; no changes
11/17	Made consistent with style guide and clarified, statement recognizing new transgender policy

Approved by Medical Policy Committee: 11/10/2020
Approved by Clinical Policy Operational Committee: 11/16; 11/17; 11/20
Policy Effective Date: 11/30/2020
Initiated: N/A

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