

# North Carolina State Health Plan

for Teachers and State Employees and  
NC Health Choice for Children

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## North Carolina Health Choice Medical Policy

### Reconstructive & Cosmetic Surgeries Policy Number: NCHCSU0575

**Active policy, no longer scheduled for routine review.**

**See also medical policies on Mammoplasties NCHCSU0300, Excision of Gynecomastia NCHCSU0185, Orthognathic Surgery NCHCSU0410, Keloids NCHCSU0250, and Use of the Claims Processing Contractor Medical Policies for the NHC Program NHCAD0660**

#### **Definition:**

Reconstructive surgery is any surgical procedure performed to raise patients to their optimum functioning level. The need may be as a result of an accidental injury, disease, developmental or congenital anomaly or previous therapeutic intervention. Although the surgical procedure may have inherent cosmetic effects, it is primarily considered to be reconstructive in nature.

Cosmetic surgery is any surgery which is done to revise or change the texture, configuration, or relationship with contiguous structures of any feature of the human body which would be considered to be within the range of normal and acceptable variation for age and ethnic origin.

#### **Coverage:**

- I. Reconstructive surgery is covered when the primary purpose of the surgery is to address significant functional impairment or other significant physiological problems due to congenital or developmental anomaly or due to deformity resulting from disease, trauma or prior covered therapeutic intervention.
- II. Cosmetic surgery or procedures and reconstructive surgery or procedures solely for beautifying purposes are not covered, except for the following specific indications.
  - A. Cosmetic surgery or treatment for correction of damage caused by accidental injury while the individual is continuously covered by the health benefit plan is covered.
  - B. Reconstructive breast surgery resulting from a mastectomy is covered. The coverage shall include all stages and revisions of reconstructive breast surgery performed on a non-diseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer or breast disease; reconstructive breast surgery means surgery performed as a result of a mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound and creation of a new nipple/areolar complex. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty and mastopexy of the non-diseased breast. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction.
  - C. Benefits are provided for specialized dental and orthodontic care required for treatment of cleft palate.

All other cosmetic surgery or procedures and all other reconstructive surgery or procedures solely for beautifying purposes are non-covered.

III. This policy is not intended to imply coverage for services that are specifically excluded by the NC Health Choice Program, (such as, but not limited to, dental implants).

IV. The following are guidelines for some of the most frequently performed cosmetic and reconstructive procedures:

A. Rhinoplasty and Septoplasty

1. Rhinoplasty may be considered medically necessary and eligible for coverage in the following conditions:
  - a. For deformities of the bony nasal pyramid (nasal bones and nasal process of the maxilla) that:
    - i. directly cause significant and symptomatic airway compromise, sleep apnea or recurrent or chronic rhinosinusitis, and
    - ii. are not responsive to appropriate medical management.
  - or
  - b. For reconstruction following removal of nasal malignancy, destructive inflammatory diseases (e.g., Wegener's granulomatosis, pleomorphic granulomatosis), abscess or osteomyelitis that has caused severe deformity and breathing difficulty, or
  - c. For deformity of the bony nasal pyramid caused by specifically documented trauma that occurred while the member was covered under the health benefit plan (and with continuous coverage since that time), or
  - d. For trauma-related nasal airway obstruction leading to chronic rhinosinusitis NOT RESPONDING TO MEDICAL THERAPY, regardless of date of injury.
2. Septoplasty to correct breathing difficulties is covered under the following circumstances:
  - a. Nasal septum trauma, occurring during Plan coverage (and with continuous coverage under the Plan since that time), resulting in significant deformity that was not present prior to the injury.
  - b. Need for reconstruction after the removal of a tumor, nasal polyps, or surgical removal of part of the ethmoid bone (ethmoidectomy or turbinate reduction).
  - c. A deviated septum that produces chronic nasal obstruction and results in significant medical disabilities, such as:
    - i. Recurrent purulent sinusitis (more than three episodes per year) resulting in middle meatus complex obstruction on the same side with medical record documentation of all of the following:
      - (a) Symptoms including purulent nasal discharge; and
      - (b) Radiologic evidence of chronic recurrent sinusitis (clouding of sinuses, thickening of sinus membranes on plain films or limited CT); and
      - (c) Failure of conservative management to alleviate or prevent episodes of sinusitis, including treatment with all of the following:
        - (i). Appropriate antibiotics; and
        - (ii). Nasal sprays, decongestants, antihistamines and/or topical steroids; and
        - (iii). Specific and sincere attempt to discontinue nasal irritants, including smoking, occupational exposure, drugs and inadequate humidification.
    - ii. A nasal septal deformity or nasal spur with greater than a 50% airway obstruction and medical record documentation of all of the following:
      - (a) Persistent symptoms of clinically significant nasal airway obstruction or difficult nasal breathing (i.e., heavy snoring, mouth breathing, sleep apnea, interference with daily activities due to loss of sleep and accompanying fatigue, headache, poor concentration); and
      - (b) Allergic history and testing have been performed where indicated; and
      - (c) If allergic rhinitis is present, conservative measures have failed, including: allergic precautions, antihistamines, topical nasal steroids, and desensitization injections if indicated; and

(d) General conservative management has failed, including reduction of all nasal irritants, including smoking, occupational exposures, drugs, and inadequate humidification.

- d. Recurrent nose bleeds (four or more significant episodes) which are believed to be caused by a nasal spur or septal deformity causing abnormal air flow, and which have failed to respond to conservative measures (such as avoidance of medications affecting coagulation, adding humidity to the environment and cauterization, as appropriate.)
  - e. Patient has unusual face pain that originates from the nasal area and is relieved by septal anesthesia.
  - f. Patient has an impending septal perforation AND there is significant septal deviation with airflow obstruction, AND conservative measures have failed (including humidification, avoidance of trauma, reduction of nasal irritants, and stopping offending drug therapy, including decongestants, nasal steroids, antihistamines, if indicated).
  - g. Patient has obstructive sleep apnea with a documented respiratory disturbance index (RDI) greater than five and septoplasty is being performed to enhance continuous positive airway pressure or bi-level positive airway pressure device (CPAP or BiPAP) effectiveness with clinically significant nasal obstruction documented as the cause of intolerance to CPAP/BiPAP. May be performed in conjunction with a uvulopalatopharyngoplasty (UPPP).
3. Rhinoplasty and/or septoplasty for change in the appearance of the nose is for cosmetic effect and is not covered except for procedures performed for correction of significant deformity that is due to specifically documented trauma occurring while the member has been continuously covered under the Plan. Rhinoplasty and septoplasty are not covered for any indication not meeting the above coverage criteria.

#### B. Hair Transplants

1. Hair transplants for normal baldness are not covered.
2. The correction of scalp deformity and defects due to trauma, or due to prior surgery for trauma or tumor, is covered.

#### C. Panniculectomy (abdominoplasty or tummy tuck procedure)

Surgical removal of redundant skin and fat folds is generally considered cosmetic and is not covered. A panniculectomy may be considered medically necessary and eligible for coverage under the Plan when there is medical record documentation that **ALL** of the following criteria are met:

1. The pannus hangs at or below the level of the pubic symphysis (photographs may be required); **and**
2. Causes recurrent and significant bacterial cellulitis, that has failed at least two treatments with an oral antibiotic; **and**
3. Is unresponsive to conservative treatment including adequate hygiene and topical anti-infective medications, **and**
4. Has been present for over a six month period resulting in fibrosis and thickening of the pannus with discoloration and/or lymphedema or peau d'orange effect (pitting or prominence of pores due to fibrosis and swelling) of the overlying skin; **and (if applicable)**
5. If there has been a significant weight loss (>100lbs) either criterion a. or b. below must **also** be met
  - a. If the weight loss was accomplished without bariatric surgery, the member must have maintained a stable weight for a minimum of six months, **or**
  - b. If the weight loss is a result of bariatric surgery, at least 18 months must have elapsed since the bariatric surgery and the member's weight must have been stable for the most recent six months.

#### D. Venous Stars and Spider Veins

1. Injection of sclerosing solution into venous stars, spider veins or cutaneous telangiectasia is for cosmetic effect and is not covered.

2. Hyfrecaction, laser treatment, and electro-dessication of venous stars, spider veins or superficial varicosities are non-covered cosmetic procedures.
- E. Chemical Peels
1. Chemical peels are considered to be cosmetic and not eligible for coverage when used to treat photoaged skin, wrinkles or acne scarring.
  2. Chemical peels used to treat patients with numerous (>10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical, may be considered medically necessary.
  3. Chemical peels used to treat patients with active inflammatory acne that have failed a trial of topical and/or oral antibiotic acne therapy are considered medically necessary.
- F. Rosacea
1. Non-pharmacologic treatment of rosacea, including, but not limited to dermabrasion, chemical peels, laser treatment and light therapy is considered cosmetic and not eligible for coverage.
- G. Rhytidectomy (face lift and chin augmentation)
1. No benefits are provided for face-lifting procedures or for removal of fat pads and/or redundant skin
- H. Oral Reconstruction Devices (obturators)
1. Benefits are available on an individual consideration basis for dental/oral reconstruction procedures necessitated by head and/or neck cancer surgery. Oral reconstruction is a necessity to return the patient to normal functions of speaking and eating.
  2. The durable medical equipment code DM495 has been designated for oral reconstruction devices.
- I. Suction Lipectomy
1. Suction lipectomy for the removal of a localized lipoma (fatty tumor) in a patient of normal body weight is covered.
  2. Suction lipectomy for the removal of fatty tissues solely for cosmetic purposes is not covered.
- J. Genioplasty (horizontal osteotomy of the mandible)
1. Genioplasty is considered cosmetic and not eligible for benefits.
- K. Electrolysis or Laser Hair Removal
1. Electrolysis or laser hair removal for hirsutism is considered cosmetic and not eligible for benefits.

**Approval Procedures:**

- I. Prior approval is required for blepharoplasties, surgery for hermaphroditism, excision of keloids, reduction mammoplasty, morbid obesity surgery, excision of gynecomastia, revision of the nasal structure, subcutaneous injection of filling material, suction lipectomy, abdominoplasty, orthognathic surgery and varicose vein treatment, including sclerotherapy, endoluminal radiofrequency ablation, endovenous laser ablation and ligation and excision of varicose veins.
- II. A letter of medical necessity signed and dated by the surgeon must be submitted to the Medical Review section prior to rendering the service.
- III. Documentation must include:
  - A. Member identification number
  - B. Patient's mailing address
  - C. Date of the injury or onset of the disease
- IV. For oral reconstruction procedures necessitated by head and/or neck surgery, documentation must also include:
  - A. Medical records, including history and physical
  - B. Operative report
  - C. Findings of oral examinations
  - D. Related radiographs (including pre-disease state)
  - E. Treatment plans
- V. For suction lipectomy, documentation must also include:
  - A. Patient's height, weight and date of birth

- B. Location & size of tumor
- C. Pre-operative photographs
- VI. Pre-operative photographs and medical records may be requested for other procedures depending on the specific clinical indication and procedure

**Limitations and Exclusions:**

- I. Reconstructive surgery is limited to the injured or diseased portion of the body.
- II. Cosmetic surgery or related procedures done solely beautifying purposes is not covered.
- III. Services received in treatment of complications due to a previously performed cosmetic procedure are not covered if the complications were known at the time the non-covered services were provided.

**Source:**

- G.S. 135-42(b)
- G.S. 108A-70.21(b)
- G.S. 135-40.6 (6) b (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.6A (b) 7(a-I), (8), (9) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.7(14) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.6A(a)4 (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.7(20) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.7(21) (statute effective through 06/30/2008 for Predecessor Plan)

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