Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate.

Dean Advantage-Plastic and Reconstructive Surgery

This policy is specific to the Dean Advantage product.

Covered Service: Yes—when meets criteria below

Prior Authorization Required: Yes—as shown below

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.

Dean Health Plan Medical Policy:

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

2.0 Procedures that **do not require prior authorization** and are considered medically appropriate 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: covered 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 up facial muscles

   2.4 Removal of lesions or warts:

      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
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2.4.4 When clinical uncertainty of diagnosis exists, particularly where malignancy is a realistic consideration based on lesional appearance, or prior biopsy

2.5 Cleft lip/palate repair professional services at a multidisciplinary Cleft Palate Clinic (such as, speech pathologist, ENT, plastic surgeons, dental and oral surgeons) that are considered medically appropriate 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 appropriate to correct the following diagnosis:

- 3.1 Microtia: covered 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 Quality and Care Management Division and may be considered medically necessary to treat skin disease complaints only if there are both a:

- 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 is cosmetic but will be covered without prior authorization 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 Quality and Care Management Division with review by a medical director and is considered medically appropriate 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 Quality and Care Management Division and is considered medically appropriate in the following clinical situations:

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

8.0 Examples of procedures that are generally performed to enhance appearance and are not medically necessary include:

- Abdominoplasty
- Chemodenervation for wrinkle reduction
- Collagen implants for other than incontinence
- Complications of tattooing or body piercing, such as torn ear lobes, allergic reactions
- Correction of flop ears
- Dermabrasion
- Face and brow lifts
- Liposuction
- Removal of lesions/skin tags; scars that are asymptomatic
- Removal of extra digits (unless there is a functional deficit)
- Sclerotherapy for spider veins or telangectasia

Committee/Source

Originated: Medical Director Committee/Quality and Care Management Division

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- Medical Policy Committee/Quality and Care Management Division

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