Marketplace Benefit Interpretation

# Marketplace National Regional Benefit Interpretation Document

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| Benefit Name | COSMETIC, RECONSTRUCTIVE OR PLASTIC SURGERY |
| Applicable State | California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin |
| Benefit Definition | This policy addresses cosmetic, reconstructive, and plastic surgical procedures.<br><br>Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.<br><br>**Essential Health Benefits for Individual and Small Group**<br>For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.<br><br>**A. FEDERAL/STATE MANDATED REGULATIONS**<br><br>**Note: The most current federal/state mandated regulations for each state can be found in the links below.**<br><br>**FEDERAL:**<br>Federal Requirements in Women's Health and Cancer Rights Act of 1998 (P.L. 105-277)- Breast reconstruction, if mastectomy is covered |

**CALIFORNIA:**

California Health & Safety Code §1367.63

**FLORIDA:**

Fla. Stat. § 627.64193: Required coverage for cleft lip and cleft palate

Individual - Fla. Stat. § 627.64171; HMO Contract - Fla. Stat. § 641.31(31) - Post-mastectomy length of stay and out-patient coverage

Individual - Fla. Stat. § 627.6417; HMO Contract - Fla. Stat. § 641.31(32) - Mastectomy: Surgical procedures and devices

Individual - Fla. Stat. § 627.64193; HMO Contract - Fla. Stat. § 641.31(35) - Cleft lip/palate for children

**IDAHO:**

Federal Requirements in Women's Health and Cancer Rights Act of 1998 (P.L. 105-277)- Breast reconstruction, if mastectomy is covered

Congenital Anomaly (e.g., cleft lip and palate)
ID Admin Code 18.01.06: RULE TO IMPLEMENT UNIFORM COVERAGE FOR NEWBORN AND NEWLY ADOPTED CHILDREN

**ILLINOIS:**

Post-Mastectomy Care
215 ILCS 5/356t
215 ILCS 125/4-6.5

**KENTUCKY:**

Ky. Rev. Stat. § 304.17A-134 - Coverage for medical and surgical benefits with respect to mastectomy, diagnosis and treatment of endometrioses and endometritis, and bone density testing -- Requirements for health benefit plan.
Ky. Rev. Stat. § 304.17A-139- Reconstructive Surgery

**MICHIGAN:**

MCL500.3406d- Breast cancer outpatient treatment services/Breast cancer rehabilitation services/Mastectomy prosthetics/Breast cancer diagnostic service

**MISSISSIPPI:**

Mississippi Department of Insurance Regulation 2000-3 Women's Health and Cancer Rights- Breast reconstruction where a mastectomy was performed

**NEW MEXICO:**

NMSA 59A-22-39.1- Mastectomies and Lymph Node Dissection; Minimum Hospital Stay Coverage

NMSA 59A-46-41.1- Mastectomies and Lymph Node Dissection; Minimum Hospital Stay Coverage Required.

A. Each individual and group health maintenance contract delivered or issued for delivery in this state shall provide coverage for not less than forty-eight hours of inpatient care following a mastectomy and not less than twenty-four hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

B. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician and patient determine that a shorter period of hospital stay is appropriate.

C. Coverage for minimum inpatient hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same contract.

**History:** 1978 Comp., § 59A-46-41.1, enacted by Laws 1997, ch. 249, § 4.

**SOUTH CAROLINA:**

S.C. Code Ann. § 38-71-125- Mastectomies; hospitalization requirements; early release provisions

S.C. Code Ann. § 38-71-130- Breast reconstruction and prosthetic devices

S.C. Code Ann. §38-71-240- Cleft Lip and Palate

**TEXAS:**

Texas Insurance Code Sec. 1367.153. Reconstructive Surgery for Craniofacial Abnormalities; Definition Required.

TIC §1367.003- Women's Health - Mastectomy, Reconstructive Surgery

TIC §1357.004- Women's Health - Mastectomy, Reconstructive Surgery

28 TAC §11.509(5): Additional Mandatory Benefit Standards: Individual and Group Agreements

28 TAC § 11.508(b)(1)- Women's Health - Mastectomy, Reconstructive Surgery

TIC §§1367.151 - 1367.153

**UTAH:**

31A-22-630- Mastectomy coverage

**WASHINGTON:**

RCW 48.44.212, Coverage of dependent children to include newborn infants and congenital anomalies from moment of birth -Notification Period.

RCW 48.20.395; 48.21.230; 48.46.280, - Reconstructive breast surgery resulting from a mastectomy due to disease, illness or injury

48.46.285- Mastectomy, lumpectomy

**WISCONSIN:**

632.895 (13)- Breast Reconstruction

**B. STATE MARKET PLAN ENHANCEMENTS**

**None**

**C. COVERED BENEFITS**

**IMPORTANT NOTE**: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

## RECONSTRUCTIVE SURGERY

**CALIFORNIA:**

**Reconstructive Surgery:** Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function or create a normal appearance, to the extent possible.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

**FLORIDA, IDAHO, MISSISSIPPI, OHIO, SOUTH CAROLINA, UTAH, WISCONSIN:**
**Reconstructive Surgery:** Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

**ILLINOIS:**
**Reconstructive Surgery:** Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, conditions resulting from accidental injuries, developmental abnormalities, scars, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.
- Removal of breast implant if medically necessary.

**KENTUCKY:**
**Reconstructive Surgery**: Passport covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities,

trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery, and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

**MICHIGAN:**
**Reconstructive Surgery**: Molina covers the following reconstructive surgery services when Prior Authorized:
- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

The following Medically Necessary surgeries:
  - Blepharoplasty of upper lids
  - Breast reduction
  - Surgical treatment of male gynecomastia
  - Panniculectomy
  - Sleep apnea treatments – including rhinoplasty and septorhinoplasty

**NEW MEXICO:**
**Reconstructive Surgery**: Molina covers the following reconstructive surgery services when Prior Authorized:
- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.
- Medically necessary services related to gender affirming care and the treatment for gender dysphoria

**TEXAS:**

**Reconstructive Surgery:** Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas
- For a child who is younger than 18 years of age, Molina covers reconstructive surgery for craniofacial abnormalities. Such coverage includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

**WASHINGTON:**

**Reconstructive Surgery**: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function, including for newborn Members.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery, and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

**ALL STATES:**

For Covered Services related to reconstructive surgery, you will pay the Cost Sharing the member would pay if the Covered Services were not related to reconstructive surgery. For example, for hospital inpatient care, you would pay the Cost Sharing listed under “Inpatient Hospital Services” in the Schedule of Benefits.

## DENTAL AND ORTHODONTIC SERVICES FOR CLEFT PALATE & LIP

**ALL STATES:**

**Dental and Orthodontic Services for Cleft Palate & Lip**

We cover dental extractions when medically necessary to prepare for orthodontic services for cleft palate and lip, if they meet all of the following requirements:

- The services are an integral part of a reconstructive surgery for cleft palate
- A Participating Provider provides the services or Molina Healthcare authorizes a Non-Participating Provider who is a dentist or orthodontist to provide the services

**CALIFORNIA, IDAHO, ILLINOIS, KENTUCKY, MISSISSIPPI, NEW MEXICO, TEXAS, UTAH, WASHINGTON, WISCONSIN:**
Dental and Orthodontic services for Cleft Palate

**FLORIDA:**
Dental and Orthodontic services for cleft lip and cleft palate

**MICHIGAN:**
Dental and Orthodontic services that are an integral part of a reconstructive surgery for cleft palate

**OHIO:**

- Dental and Orthodontic services that are an integral part of a reconstructive surgery for cleft palate

- Dental services that are integral to transplant preparation, initiation of immunosuppressives, and direct treatment of acute head and neck traumatic injury, head and neck cancers, or cleft palate

**SOUTH CAROLINA:**

- Dental and Orthodontic services for cleft palate
- Molina covers Medically Necessary care and treatment for cleft lip and palate, as well as for any condition or illness which is related to or developed as a result of a cleft lip and palate, as required by State Law.

## MORE INFORMATION

Please refer to the Benefit Interpretation Policies titled **Dental Care and Oral Surgery**, **Gender Dysphoria** and **Post Mastectomy** for more information

**D. NOT COVERED**

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

## RECONSTRUCTIVE SURGERY

**CALIFRONIA, FLORIDA, IDAHO, ILLINOIS, KENTUCKY, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN:**

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance
- Surgery that does not result in a clinically significant improvement in a normal body function is not covered (Clinical Perspective on 3/16/2021)

## COSMETIC SERVICES

**CALIFORNIA:**

**Cosmetic Services:** Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

**FLORIDA, KENTUCKY, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN:**

**Cosmetic Services:** Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to any services specifically covered in any section of this policy.

**IDAHO:**

**Cosmetic Services:** Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to medically necessary reconstructive services specifically covered in any section of this Agreement, including breast reconstruction following a mastectomy.

**ILLINOIS:**

**Cosmetic Services:** Surgery, services, and supplies that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to any services specifically covered in any section of this Agreement.

**IL Benchmark:** Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases.

## HAIR LOSS OR GROWTH TREATMENT

**CALIFORNIA:**
**Hair Loss or Growth Treatment:** Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder**.**

**FLORIDA, IDAHO, ILLINOIS, KENTUCKY, MICHIGAN, MISSISSIPPI, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN:**
**Hair Loss or Growth Treatment:** Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered.

**E. DEFINITIONS**

See Glossary

**F. POLICY HISTORY/REVISION INFORMATION**

| Date | Action/Description |
|---|---|
| 4/15/2021 | • Added KY 2022 Drafted Language |
| 5/14/2021 | • Added IL 2022 EOC Language |
| 6/28/2021 | • Added ID 2022 EOC Language |

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| Procedure Codes (Internal Use Only) | BI Policy Configuration Cosmetic, Reconstructive or Plastic Surgery<br><br>**Coding Disclaimer:** Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). |

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<tr><td></td><td>Due to changing industry practices, Molina reserves the right to revise this policy as needed.</td></tr>
<tr><td>Prior Authorization</td><td>For the MHI PA Matrix, if a code is NOT listed, it could EITHER be:<br>a. Covered and No PA Required<br>b. Not Covered<br><br>You cannot use the MHI PA Matrix to make coverage determinations.<br><br>PA Lookup Tool</td></tr>
<tr><td>Approval</td><td>
<table>
<tr><th>Departments</th><th>Product</th><th>CIM</th><th>Clinical Management</th></tr>
<tr><td>Date (Initial)</td><td>12/22/2020</td><td>12/18/2020</td><td>3/16/2021</td></tr>
<tr><td>Revised (for 1/1/2022)</td><td>10/26/2021</td><td>3/2/2022</td><td>10/26/2021</td></tr>
<tr><td>Revised (for 1/1/2023)</td><td>10/27/2022</td><td></td><td>10/27/2022</td></tr>
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