To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair)
1A-12, Breast Surgeries
1A-15, Surgery for Clinically Severe or Morbid Obesity
1-O-2, Craniofacial Surgery
1-O-3, Keloid Excision and Scar Revision
1-O-5, Rhinoplasty and/or Septoplasty
4A, Dental Services
4B, Orthodontic Services

1.0 Description of the Procedure, Product, or Service

Reconstructive Surgery

Reconstructive surgery is performed to treat body parts affected aesthetically or functionally by congenital defects, developmental abnormalities or trauma.

Cosmetic Surgery

Cosmetic plastic surgery includes surgical and nonsurgical procedures that enhance and reshape structures of the body to improve appearance and confidence.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover reconstructive and cosmetic surgery when the beneficiary meets the following specific criteria:

a. improves or restores physical function;
b. corrects significant deformity resulting from disease, trauma, accidental injury, or previous therapeutic process;
c. corrects congenital or developmental anomalies that have resulted in significant functional impairment or disfigurement; **or**
d. corrects acquired deformities.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover the following:

a. **Cosmetic Surgery**
Cosmetic surgery, as defined in **Section 1.0,** is not covered. Psychiatric or emotional distress **is not** considered a medical necessity indicator for cosmetic procedures.

The following procedures are always considered to be cosmetic and therefore are not covered:

1. augmentation of small breasts;
2. buttocks or thigh lifts;
3. diastasis recti repair;
4. ear piercing;
5. hair removal of any method;
6. excision or correction of frown lines;
7. hair implants or transplants for alopecia;
8. laser skin resurfacing; **and**
9. psoralens ultraviolet A (PUVA) treatment for vitiligo.

b. **Reconstructive Surgery**
Reconstructive surgery or procedures are not covered in the absence of documentation that the procedure will be performed primarily to restore/improve function or to correct deformity resulting from congenital or developmental anomaly, disease, trauma, or previous therapeutic process.

Excision of excessive skin and subcutaneous tissue (including lipectomy) are always considered cosmetic when medical necessity for reconstructive surgery is not met. If medical necessity is documented, prior approval may be submitted as a reconstructive surgery request.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Reconstructive Cosmetic and Surgery. The provider shall obtain prior approval before rendering Reconstructive Cosmetic and Surgery.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and

b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

The following information must be submitted electronically by the rendering provider via the NCTracks Provider Portal with the prior approval request to determine medical necessity:

a. the location and cause of the defect;
b. medical reasons for the procedure;
c. pre-surgery medical photographs of the defect;
d. listing of the CPT codes describing the procedures to be performed;
e. documentation of pain, infection, and irritation; **and**
f. documentation of function that will be improved or restored.

Note: For Medicaid coverage criteria and prior approval requirements for dental, breast, brow, craniofacial, bariatric, rhinoplasty, keloid and scar revision procedures, refer to criteria in specific policies available at https://medicaid.ncdhhs.gov/. Clinical Coverage Policy 1-O-1 does not apply to these services.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for

Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1985

Revision Information:

Date	Section Revised	Change
10/01/2008	Throughout	Initial promulgation of current coverage.
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/12/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1S-4 under Session Law 2011-145, § 10.41.(b)
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
11/01/2012	Subsection 4.2.1	Moved "Excision of excessive skin and subcutaneous tissue (including lipectomy) of the following areas are always considered to be cosmetic when medical necessity for reconstructive surgery is not met: 1. Thigh. 2. Leg. 3. Hip. 4. Buttock. 5. Arm. 6. Forearm or hand. 7. Submental fat pad. 8. All other areas." to Subsection 4.2.2.
11/01/2012	Throughout	Replaced "recipient" with "beneficiary."
11/01/2012	Subsection 4.2.1	Added "**Note**: For breast procedures additional medical coverage criteria is listed in clinical coverage policy 1A-12, Breast Surgeries: http://www.ncdhhs.gov/dma/mp/.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
01/01/2016	Subsection 4.2.1.a	Deleted, "Electrolysis for hirsutism." Added "Hair removal-any method."
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
01/3/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
01/3/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
01/15/2023		Added 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) and 1-O-2 Craniofacial Surgery to the Related Clinical Policy Coverage list

Date	Section Revised	Change
01/15/2023	Throughout policy	Changed the word "patient" and "recipient" to beneficiary. Made text gender neutral.
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.
12/15/2023		Fixed minor formatting issue; posting and amended date not changed.
09/01/2024	Page 1	Added 1A-15, Surgery for Clinically Severe or Morbid Obesity, 1-O-3, Keloid Excision and Scar Revision and 1-O-5, Rhinoplasty and/or Septoplasty under Related Clinical Coverage Policies.
09/01/2024	Subsection 1.0	Updated the definitions of Reconstructive and Cosmetic Surgery.
09/01/2024	Subsection 3.2.1.b.	Added the text "accidental injury."
09/01/2024	Subsection 3.2.1.d.	Removed text that included a non-inclusive list of examples.
09/01/2024	Subsection 4.2.1(b)	Removed text that included a non-inclusive list of examples.
09/01/2024	Subsection 5.1	Removed "The provider shall obtain prior approval before rendering either cosmetic or reconstructive surgery"
09/01/2024	Subsection 5.2	Added Note: For Medicaid coverage criteria and prior approval requirements for dental, breast, brow, craniofacial, bariatric, rhinoplasty, keloid and scar revision procedures, refer to criteria in specific policies available at https://medicaid.ncdhhs.gov/. Clinical Coverage Policy 1-O-1 does not apply to these services.
09/01/2024	Subsection 5.2.2	Clarified language to state the rendering provider must submit the PA request
09/01/2024	Subsection 5.3	Removed subsection and added dental to the Note in subsection 5.2
09/01/2024	Throughout the policy	Clarifying language and the removal of partial non-inclusive lists.

Attachment A: Claims-Related Information

Provider(s) shall comply with the *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Providers should contact the DMA fiscal agent to check service coverage or prior approval status.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Office, Clinic, Ambulatory Surgery Center.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/