

## **Table of Contents**

|       |                                                                                                                 |   |
|-------|-----------------------------------------------------------------------------------------------------------------|---|
| 1.0   | Description of the Procedure, Product, or Service.....                                                          | 1 |
| 1.1   | Reconstructive Surgery.....                                                                                     | 1 |
| 1.2   | Cosmetic Surgery.....                                                                                           | 1 |
| 2.0   | Eligibility Requirements .....                                                                                  | 1 |
| 2.1   | Provisions.....                                                                                                 | 1 |
| 2.1.1 | General.....                                                                                                    | 1 |
| 2.1.2 | Specific .....                                                                                                  | 2 |
| 2.2   | Special Provisions.....                                                                                         | 2 |
| 2.2.1 | EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age ..... | 2 |
| 2.2.2 | EPSDT does not apply to NCHC beneficiaries .....                                                                | 3 |
| 2.2.3 | Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age .....             | 3 |
| 3.0   | When the Procedure, Product, or Service Is Covered.....                                                         | 3 |
| 3.1   | General Criteria Covered .....                                                                                  | 3 |
| 3.2   | Specific Criteria Covered.....                                                                                  | 3 |
| 3.2.1 | Specific criteria covered by both Medicaid and NCHC .....                                                       | 3 |
| 3.2.2 | Medicaid Additional Criteria Covered.....                                                                       | 4 |
| 3.2.3 | NCHC Additional Criteria Covered .....                                                                          | 4 |
| 4.0   | When the Procedure, Product, or Service Is Not Covered.....                                                     | 4 |
| 4.1   | General Criteria Not Covered .....                                                                              | 4 |
| 4.2   | Specific Criteria Not Covered.....                                                                              | 4 |
| 4.2.1 | Specific Criteria Not Covered by both Medicaid and NCHC.....                                                    | 4 |
| a.    | Cosmetic Surgery.....                                                                                           | 4 |
| b.    | Reconstructive Surgery.....                                                                                     | 5 |
| 4.2.2 | Medicaid Additional Criteria Not Covered.....                                                                   | 5 |
| 4.2.3 | NCHC Additional Criteria Not Covered.....                                                                       | 5 |
| 5.0   | Requirements for and Limitations on Coverage .....                                                              | 6 |
| 5.1   | Prior Approval .....                                                                                            | 6 |
| 5.2   | Prior Approval Requirements .....                                                                               | 6 |
| 5.2.1 | General.....                                                                                                    | 6 |
| 5.2.2 | Specific .....                                                                                                  | 6 |
| 5.3   | Dental Reconstructive and Cosmetic Surgery .....                                                                | 6 |
| 6.0   | Provider(s) Eligible to Bill for the Procedure, Product, or Service .....                                       | 6 |
| 6.1   | Provider Qualifications and Occupational Licensing Entity Regulations.....                                      | 6 |
| 6.2   | Provider Certifications .....                                                                                   | 7 |
| 7.0   | Additional Requirements .....                                                                                   | 7 |
| 7.1   | Compliance .....                                                                                                | 7 |
| 8.0   | Policy Implementation/Revision Information.....                                                                 | 8 |

|                                                                                                                                             |    |
|---------------------------------------------------------------------------------------------------------------------------------------------|----|
| Attachment A: Claims-Related Information .....                                                                                              | 9  |
| A. Claim Type .....                                                                                                                         | 9  |
| B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-<br>CM) and Procedural Coding System (PCS)..... | 9  |
| C. Code(s).....                                                                                                                             | 9  |
| D. Modifiers.....                                                                                                                           | 9  |
| E. Billing Units.....                                                                                                                       | 9  |
| F. Place of Service .....                                                                                                                   | 10 |
| G. Co-payments .....                                                                                                                        | 10 |
| H. Reimbursement .....                                                                                                                      | 10 |

**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:

1A-12, Breast Surgeries  
4A, Dental Services  
4B, Orthodontic Services

## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Reconstructive Surgery**

Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level. The need may be a result of congenital deformity, an accident, infection, disease, or, in some cases, aging or a previous therapeutic process. Although a surgical procedure may have inherent cosmetic effects, it is considered to be primarily reconstructive in nature.

### **1.2 Cosmetic Surgery**

Cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Cosmetic surgery is intended primarily to preserve or improve appearance.

## **2.0 Eligibility Requirements**

### **2.1 Provisions**

#### **2.1.1 General**

***(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)***

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

### 2.1.2 Specific

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

- a. Medicaid  
None Apply.
- b. NCHC  
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: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary

**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 and NCHC 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 both Medicaid and NCHC**

Reconstructive surgery is covered when the procedure does one of the following:

- a. Improves or restores physical function.
- b. Corrects significant deformity resulting from disease, trauma, or previous therapeutic process.
- c. Corrects congenital or developmental anomalies that have resulted in significant functional impairment or disfigurement.

Some common examples of congenital abnormalities are birthmarks, cleft lip and palate deformities, hand deformities such as syndactyly (webbed fingers) or extra or absent fingers, and abnormal breast development (for example Poland's Syndrome).

Burn wounds, lacerations, growths, and aging problems are considered acquired deformities. For example, some older adults with redundant or drooping eyelid skin blocking their fields of vision might have eyelid surgery.

### **3.2.2 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.3 NCHC 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 and NCHC 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 both Medicaid and NCHC**

##### **a. Cosmetic Surgery**

Cosmetic surgery, as defined in **Section 1.0**, is not covered. Psychiatric and/or emotional distress **is not** considered a medically necessary 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. Electrolysis for hirsutism.
6. Excision/correction of frown lines.
7. Hairplasty for alopecia.
8. Laser skin resurfacing.
9. Psoralens ultraviolet A (PUVA) treatment for vitiligo.

**Note:** For breast procedures additional medical coverage criteria is listed in clinical coverage policy 1A-12, Breast Surgeries:  
<http://www.ncdhhs.gov/dma/mp/>.

#### **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) of the following areas are always considered cosmetic when medical necessity for reconstructive surgery is not met. If medical necessity is documented, prior approval for the following surgical areas may be submitted as a reconstructive surgery:

1. Abdomen.
2. Thigh.
3. Leg.
4. Hip.
5. Buttock.
6. Arm.
7. Forearm or hand.
8. Submental fat pad.
9. All other areas.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

## 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 and NCHC shall require prior approval for either cosmetic or reconstructive surgery. The provider shall obtain prior approval before rendering either cosmetic or reconstructive 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 with each prior approval request form 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.
- f. Documentation of function that will be improved or restored.

**Note:** Some reconstructive procedures have additional medical coverage criteria that are listed in separate policies: <http://www.ncdhhs.gov/dma/mp/>.

### 5.3 Dental Reconstructive and Cosmetic Surgery

Dentists should refer to Clinical Coverage Policies 4A, *Dental Services*, and 4B, *Orthodontic Services*: <http://www.ncdhhs.gov/dma/mp/>.

## 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 or NCHC 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 DMA'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 " <b>Note:</b> For breast procedures additional medical coverage criteria is listed in clinical coverage policy 1A-12, Breast Surgeries: <a href="http://www.ncdhhs.gov/dma/mp/">http://www.ncdhhs.gov/dma/mp/</a> ."                                                                                                                 |
| 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.                                                                                                                                                                                                        |

## Attachment A: Claims-Related Information

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

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. International Classification of Diseases, 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, Attachment 4.18-A, page 1, located at  
<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at  
[http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>