Medical Necessity Guidelines: Reconstructive and Cosmetic Surgery

Effective: July 15, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

To obtain InterQual® SmartSheets™:
- **Tufts Health Plan Commercial Plan products and Tufts Health Freedom Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider website. If you are not a Tufts Health Plan provider please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404.
- **Tufts Health Public Plans products:** InterQual SmartSheet(s) available as part of the prior authorization process.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Tufts Health Plan may provide coverage for reconstructive surgery and procedures when they meet Medical Necessity Guidelines and are determined to be Medically Necessary as defined below.

I. PROCEDURES INCLUDED IN THIS POLICY WITH TUFTS HEALTH PLAN MEDICAL NECESSITY GUIDELINES:

A. General Reconstructive and Cosmetic Surgery
B. Redundant Skin – Surgical Removal (includes Abdominoplasty/Panniculectomy)
C. Hemangioma and Port Wine Stain Treatments
D. Hair Removal by Laser or Electrolysis
E. Labiaplasty

II. PROCEDURES INCLUDED IN THIS POLICY THAT REQUIRE AN INTERQUAL SMARTSHEET:

A. Breast Implant Removal
B. Gynecomastia: Surgical Correction by Mastectomy, Male
C. Reduction Mammoplasty for Symptomatic Macromastia, Female
D. Rhinoplasty
E. Scar Revision

I.THE FOLLOWING ARE FOR PROCEDURES WITH TUFTS HEALTH PLAN MEDICAL NECESSITY GUIDELINES:

I. A General Reconstructive and Cosmetic Surgery

COVERAGE GUIDELINES

Reconstructive surgery and procedures are covered when the services are necessary to relieve pain or restore a bodily function that is impaired as a result of a congenital defect, birth abnormality, traumatic injury or covered surgical procedure. Prior authorization is required.

For Massachusetts products only, consistent with Chapter 233 of the Acts of 2016, reconstructive surgery and procedures to repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome are covered when there is documentation from a treating provider that the treatment is necessary for correcting, repairing or ameliorating the effects of HIV-associated lipodystrophy syndrome1. Prior authorization is required.

In accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA)[2] and applicable state regulations, breast reconstructive procedures after mastectomy are covered for:

- all stages of reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance

LIMITATIONS

- Reconstructive surgery may not be covered for a congenital defect or birth anomalies that have not resulted in significant functional impairment.
- Cosmetic surgery or procedures are not covered at any time. Cosmetic means to change or improve appearance.

CODES

HIV-associated lipodystrophy syndrome ICD-10-CM codes:

Code	Description
B20	Human immunodeficiency virus [HIV] disease
E88.1	Lipodystrophy, not elsewhere classified

I.B Redundant Skin – Surgical Removal (includes Abdominoplasty/Panniculectomy)

Redundant skin is defined as large skin folds that are the result of a massive weight loss. Redundant skin can be present on several parts of the body. A pannus is an overhanging apron of redundant, abdominal skin. Panniculectomy, also known as an abdominoplasty, is the surgical removal of the pannus. Brachioplasty is the term used to describe the surgical removal of the redundant skin from the upper arms.

COVERAGE GUIDELINES

Tufts Health Plan may authorize coverage for the surgical removal of redundant skin if the Member meets one or more of the following criteria: (Documentation, including a letter of medical necessity is required)

- Skin necrosis, recalcitrant to conventional wound healing interventions such as debridement
- Recurrent skin infections requiring systemic antibiotics or systemic antifungals
  (Recurrent to be defined as at least two incidences in a 12-month period)
- Intertriginous skin rashes or skin ulcerations that show no signs of healing after at least 8 weeks of care under the direction of a Dermatology Specialist. (Note: Submission of the Dermatology Medical Record Documentation Required)

ADDITIONAL COVERAGE GUIDELINES

In cases where the redundant skin is the result of a medical weight loss, the weight loss must have been maintained for at least six months before the Member will be considered for a procedure based on the above criteria.

In cases where the redundant skin is the result of bariatric surgery, Tufts Health Plan will not cover the procedure until eighteen (18) months after the bariatric surgery was performed, the weight loss has been maintained for at least six (6) months and no more than an

	additional twenty (20) pound weight loss is anticipated before the Member will be considered for a procedure based on the above criteria. **LIMITATIONS** Tufts Health Plan will not cover a request for redundant skin removal if it is for any one of the following reasons as it is not considered medically necessary to do so: • An abdominoplasty or panniculectomy for: – Treatment of neck or back pain – Repair of an abdominal laxity or diastasis recti – Treatment of psychological or psychosocial issue related to redundant skin – When the procedure is performed at the time of an additional abdominal or gynecological surgery **unless** it meets the medical necessity guidelines above • Tufts Health Plan will not cover brachioplasty, thighplasty, etc. • Tufts Health Plan will not cover the surgical removal of redundant skin or body contouring for cosmetic purposes only. **CODES** The following CPT codes require prior authorization: **Code** / **Description** 15830 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy 15832 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh 15833 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg 15834 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip 15835 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock 15837 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand 15838 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
I.C Hemangioma and Port Wine Stain Treatments Hemangioma is a blood-filled birthmark or benign tumor consisting of closely packed small blood vessels. Commonly found during infancy, it first grows, and then may spontaneously disappear in early childhood without treatment. Nevus flammeus, also known as a port wine stain, is a flat capillary hemangioma that is present at birth and that varies from pale red to deep reddish purple. (cont'd) These lesions most often occur on the face. The depth of the color depends on whether the superficial, middle, or deep dermal vessels are involved. On the face the lesion persists and develops a thick, verrucous, nodular surface.	**COVERAGE GUIDELINES** Tufts Health Plan may authorize coverage of invasive treatment for cutaneous congenital hemangiomas, with a limit of 6 treatments, for Members when **ONE** of the following criteria is met: • The hemangioma is on the face and/or neck. For the purpose of this guideline, the face includes the ears. • The hemangioma compromises the function of vital structures, e.g., vocal cords. • The hemangioma is symptomatic, e.g., bleeding, painful, ulcerated, subject to recurrent infection. • The hemangioma is associated with Kasabach-Merritt syndrome. • The hemangioma is pedunculated (referring to a lesion attached with a narrow, stalk-like base). **LIMITATIONS** • Additional treatments (beyond the initial six) will require authorization with documentation provided that supports the need for additional treatments based upon the original size of the hemangioma and the treatment response to date. Up to two (2) additional treatments may be authorized per request. • Tufts Health Plan will not authorize the coverage of invasive treatments for cutaneous congenital hemangiomas and port-wine stains for cosmetic reasons only, including relating to seasonal changes in appearance of the lesions. **CODES** The following CPT codes require prior authorization:

Code	Description
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq. cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq. cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq. cm

I.D. Hair Removal by Laser or Electrolysis

COVERAGE GUIDELINES

Tufts Health Plan may authorize coverage for hair removal with laser or electrolysis, by a board-certified dermatologist or treating provider, when the Member meets one of the following criteria for planned transgender genital surgery:

- The defined area of hair removal is to treat tissue donor site(s) for a planned surgical phalloplasty
- The defined area of hair removal is to treat tissue donor site(s) for a planned surgical vaginoplasty

Documentation, including a letter of medical necessity by the treating surgeon, is required including the size and location of the area to be treated, a timeline with the expected number of treatments and expected date of planned genital surgery.

Note: Prior authorization for planned transgender surgery **must** be in place in order for Tufts Health Plan to review a request for hair removal. Refer to the Transgender Surgical Procedures or the Transgender Surgical Procedures for Tufts Health Together and RITogether Medical Necessity Guidelines for more information.

LIMITATIONS

- Tufts Health Plan considers hair removal to treat pilonidal sinus disease to be noncovered/investigational.
- Tufts Health Plan will not cover the removal of hair for cosmetic purposes. Cosmetic means to change or improve appearance.

CODES

The following CPT codes require prior authorization:

Code	Description
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue {when specified as permanent hair removal by laser}

ICD-10 Codes	Description
F64-F64.9	Gender identity disorder
Z87.890	Personal history of sex reassignment

Note: The above ICD-10-CM codes are subject to state regulations as applicable for Tufts Health Together Plans.

I.E Labiaplasty

COVERAGE GUIDELINES

Tufts Health Plan may authorize coverage for labiaplasty for a diagnosis of hypertrophy in members age 18 and older when there is documentation of one or more of the following:

- Interference in basic activities and/or functions
- Recurrent rashes or non-healing ulcers in the affected area, despite conservative topical treatment
- Dyspareunia

LIMITATIONS

Tufts Health Plan will not cover labiaplasty for cosmetic purposes.

CODES

The following CPT code requires prior authorization when billed with one of the diagnosis codes listed below:

Code	Description
56620	Vulvectomy simple; partial

ICD-10 Codes	Description
N90.60	Unspecified hypertrophy of vulva
N90.61	Childhood asymmetric labium majus enlargement
N90.69	Other specified hypertrophy of vulva

II. THE FOLLOWING ARE FOR PROCEDURES THAT REQUIRE AN INTERQUAL SMARTSHEET

Tufts Health Plan requires the use of an InterQual SmartSheet to obtain prior authorization for certain procedures. Please note the information in the Tufts Health Plan Modification to InterQual section(s) when indicated.

In order to obtain prior authorization for procedure(s), choose appropriate InterQual SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number listed above, according to Plan.

II.A Breast Implant Removal

- InterQual SmartSheet, **Breast Implant Removal**

CODES

The following CPT codes require prior authorization:

Code	Description
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast

II.B Gynecomastia: Surgical Correction by Mastectomy, Male

- InterQual SmartSheet, **Reduction Mammoplasty, Male**
- **Reduction Mammoplasty, Male (Adolescent)**

The following CPT codes require prior authorization:

Code	Description
19300	Mastectomy for gynecomastia
19318	Reduction mammaplasty

II.C Reduction Mammoplasty for Symptomatic Macromastia, Female

TUFTS HEALTH PLAN MODIFICATION TO INTERQUAL

- Criterion section **(10)** of the InterQual SmartSheet, for **'Breast reduction of contralateral breast post mastectomy'** does not require prior authorization**.**

CODES

- InterQual SmartSheets, **Reduction Mammoplasty, Female**
- **Reduction Mammoplasty, Female (Adolescent)**

The following CPT codes require prior authorization:

Code	Description
19318	Reduction mammoplasty

II.D Rhinoplasty

- InterQual SmartSheet **Rhinoplasty**

CODES

The following CPT codes require prior authorization:

Code	Description
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary, complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)

NOTE: If rhinoplasty is being requested for the indication of gender reassignment, please refer to Medical Necessity Guidelines: Transgender Surgical Procedures and Medical Necessity Guidelines: Transgender Surgical Procedures for Tufts Health Together and RITogether.

Note: For the diagnosis of cleft lip and/or cleft palate, the following CPT codes are covered **without** prior authorization:

Code	Description
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip septum, osteotomies

II.E Scar Revision

There are three InterQual SmartSheets that represent procedures for scar revision. These are:

- **Scar Revision**
- **Scar Contracture Release**
- **Keloid Revision**

TUFTS HEALTH PLAN MODIFICATION TO INTERQUAL

- Criterion section **1(A)** of the InterQual SmartSheet **Scar Revision** for **'Mismatch of vertical edges'** does not meet the findings requirement because it is considered cosmetic.

LIMITATIONS

Tufts Health Plan will not cover scar revision done for cosmetic purposes, for example: only to alter the appearance of the scar.

CODES

The following CPT code(s) require prior authorization when performed with any of the ICD-10-CM codes listed below:

CPT Code	Description
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq. cm or less
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm

11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk ; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet ; 2.6 cm to 7.5 cm
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm

ICD-10-CM Code(s):

Code	Description
L90.5	Scar conditions and fibrosis of skin
L91.0	Hypertrophic scar

LIMITATIONS:

Removal of skin tags is considered cosmetic and, therefore, not medically necessary.

REFERENCE

1. Massachusetts Session Laws, Chapter 233 of the Acts of 2016, An Act relative to HIV-Associated lipodystrophy syndrome treatment (effective November 8, 2016). Available at: https://malegislature.gov/Laws/SessionLaws/Acts/2016/Chapter233. Last accessed June 26, 2020.
2. Women's Health and Cancer Rights Act of 1998 (WHCRA). Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/WHCRA.html. Last accessed June 26, 2020.
3. Massachusetts Regulation, 130 CMR 406.00: Pharmacy services, 2016. Available at: https://www.mass.gov/regulations/130-CMR-40600-pharmacy-services. Last accessed July 7, 2020.
4. Rhode Island Statute TITLE 27-20-29. Mastectomy Treatment. Available at: https://www.lawserver.com/law/state/rhode-island/ri-laws/rhode_island_general_laws_27-20-29. Last accessed July 6, 2020.
5. New Hampshire Statute Title XXXVII: Insurance Chapter 417-D Women's Health Care, Section 417-D:2-b Reconstructive Surgery. Available at: http://www.gencourt.state.nh.us/. Last accessed July 6, 2020.
6. Zhang WR, Garrett GL, Arron ST, et al. Laser hair removal for genital gender affirming surgery. Translational Andrology and Urology. 2016;5(3):381-387. doi: 10.21037/tau.2016.03. Last accessed June 26, 2020
7. Hayes, Inc. Panniculectomy for treatment of symptomatic panniculi. Hayes Directory. May 19, 2016. Annual Review June 12, 2019. Last accessed June 26, 2020.
8. Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) for laser Procedures (140.5). Available at: https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=AgAAAAAAAAAA&.

APPROVAL HISTORY

January 8, 2014: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC). Eight Medical Necessity Guidelines were combined into a one-document format. These guidelines include Tufts Health Plan Medical Necessity Guidelines and procedures that require an InterQual SmartSheet™ which are cosmetic or reconstructive in nature.

Subsequent endorsement date(s) made:

- March 12, 2014: Reviewed and renewed by Integrated Medical Policy Advisory Committee (IMPAC); no changes.
- May 14, 2014: Reviewed by IMPAC, Hemangioma and Port Wine Stain Treatments guidelines were updated to include coverage for up to 6 treatments, with authorization required for the coverage of additional treatments, coverage for hemangiomas on the face and neck will not be required to meet any other coverage criteria. Gynecomastia: Surgical Correction by Mastectomy,

Male: For Tufts Health Plan Members, criteria points 130 and 140 on the InterQual SmartSheet™, Reduction Mammoplasty, Male do not need to be met for the procedure to be authorized. The effective date for these changes will be October 1, 2014.

- October 15, 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- January 1, 2015: Instructions for Tufts Health Plan – Network Health products included in this document.
- April 1, 2015: For Gynecomastia: Reduction Mammoplasty, Male: InterQual SmartSheet™ criterion section 1(C) 'Mammogram or ultrasound negative for cyst or tumor' does not need to be met for the procedure to be authorized. For Scar Revision: InterQual SmartSheet™ criterion section 1(A) 'Mismatch of vertical edges' does not meet the Findings requirement because it is considered cosmetic. For Scar Contracture Release: InterQual SmartSheet™ criterion section (2) is met when the Member has completed OT/PT ≥ to 6 weeks. For Reduction Mammoplasty, Female: InterQual SmartSheet™ criterion section (20) 'Breast reduction of contralateral breast post mastectomy' is not applicable and does not require prior authorization. See notation in the 'Tufts Health Plan Modification to InterQual section(s) within this document when indicated.
- April 8, 2015: Reviewed by IMPAC. Effective October 1, 2015, the Scar Contracture Release: InterQual SmartSheet™ criterion section (2) is met when the Member has completed OT/PT ≥ to 12 weeks. This is a change from the Tufts Health Plan Modification to InterQual of OT/PT ≥ to 6 weeks and has been removed.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- April 13, 2016: Reviewed by IMPAC. Reduction Mammoplasty for Symptomatic Macromastia, Female: InterQual SmartSheet™ criterion section (10.3) 'Mammogram or ultrasound negative for cyst or tumor' is not required for the procedure to be authorized in Member's ages 50 or less.
- October 24, 2016: Reviewed by IMPAC. Effective November 8, 2016 in accordance with Massachusetts Session Laws, Chapter 233 of the Acts of 2016, language and ICD-10-CM diagnosis codes added for HIV-associated lipodystrophy syndrome under I.A General Reconstructive and Cosmetic Surgery. Coverage guidelines added under I.D for Hair Removal by Laser or Electrolysis when the Member meets criteria for planned transgender surgery effective April 1, 2017 (link added for the Medical Necessity Guidelines: Transgender Surgical Procedures).
- March 15, 2017: Reviewed by IMPAC, under I.D for Hair Removal by Laser or Electrolysis, type of provider and documentation requirements clarified.
- April 12, 2017: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 31, 2017: Coding updated
- March 14, 2018: Reviewed by IMPAC, renewed without changes
- October 2018: Template and disclaimer updated
- December 3, 2018: 2018.2 InterQual® upgrade for Tufts Health Commercial products including Freedom. Effective December 17, 2018, InterQual® upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, InterQual® upgrade for Tufts Health RITogether.
- December 12, 2018: Reviewed by IMPAC, Tufts Health Plan Modification to InterQual note regarding "mammogram or ultrasound negative for cyst or tumor" removed from sections IIB. And IIC.
- January 9, 2019: Reviewed by IMPAC, update to sections II.B. and II.C. (addition of subsets for adolescent).
- March 20, 2019: Reviewed by IMPAC, renewed without changes.
- April 17, 2019: Reviewed by IMPAC, addition of codes to table in section II.E. (Scar Revision), effective October 1, 2019.
- December 18, 2019: Reviewed by IMPAC, section I.E. added (labiaplasty), effective February 1, 2020.
- January 1, 2020: Coding updated. Per AMA CPT®, effective January 1, 2020 the following code(s) removed from sections II.B. and II.C.: 19304.

- July 15, 2020: Reviewed by IMPAC and added language to section I.A: General Reconstructive and Cosmetic Surgery regarding WHCRA mandate. Clarified limitation to include seasonal variation under section I.C: Hemangioma and Port Wine Stain Treatments.
- July 23, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services