



KERN HEALTH SYSTEMS POLICY AND PROCEDURES

Policy Title	Reconstructive Procedures	Policy #	30.86-P
Policy Owner	Utilization Management	Original Effective Date	01/01/2026
Revision Effective Date		Approval Date	1/26/2026
Line of Business	<input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> Medicare <input type="checkbox"/> Corporate		

I. PURPOSE

To outline the process for Kern Health Systems (KHS) to review and arrange the provision of Reconstructive Surgery as defined in Health and Safety Code 1367.63, and to define the circumstances when a procedure or service is considered medically necessary and reconstructive in nature versus the circumstances when a procedure or service is considered cosmetic and therefore, not covered.

II. POLICY

- A. It is the policy of KHS to provide payment for medical and surgical procedures when covered under the Member's specific benefit plan and medically necessary.
- B. Reconstructive Services are covered when indicated and are performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, accidental injury, trauma, infection, tumors or disease for the purpose of improving/restoring body functions
- C. Procedures performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.
- D. All denials are based on medical necessity and appropriateness as determined by a KHS Medical Director or Physician Reviewer.
- E. Cosmetic Procedures are performed to reshape normal structures of the body in order to improve the patient's appearance and/or self-esteem.
- F. Reconstructive surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease, or other destructive pathology which causes functional impairment, or breast reconstruction following a mastectomy.
- G. KHS Health Plan complies with the Centers for Medicare & Medicaid Services (CMS) documents that govern coverage criteria, including but not limited to, Medicare National Coverage Determinations

(NCDs), applicable Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs), Benefit Policy Manuals, for all items, services and/or procedures that are covered benefits under Medicare.

H. Gender Dysphoria and Gender-Affirming Reconstructive Procedures

Requests for reconstructive procedures related to the treatment of gender dysphoria or gender transition are reviewed in accordance with:

1. The Member's applicable benefit plan
2. All applicable state and federal laws and regulations
3. Centers for Medicare & Medicaid Services (CMS) coverage guidance, including applicable Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs), Benefit Policy Manuals, for all items, services and/or procedures that are covered benefits under Medicare.

Gender-affirming procedures are reviewed on an individual, case-by-case basis to determine whether the requested service meets the definition of a medically necessary reconstructive service and is not performed solely for cosmetic purposes.

Coverage determinations are based on medical necessity, clinical documentation, benefit limitations, and applicable regulatory guidance.

III. DEFINITIONS

TERMS	DEFINITIONS
Reconstructive Surgery	“Re-constructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, tumors, infections, trauma, or disease to do either of the following: A. To improve function. B. To create a normal appearance, to the extent possible.
Cosmetic Surgery	“Cosmetic surgery” means surgery that is performed to alter or reshape normal structures of the body to improve appearance. A procedure might be considered either cosmetic or medical depending on the reason for it (e.g., breast reduction surgery for pain).
Gender Dysphoria	Gender dysphoria means a condition in which an individual experiences distress or impairment related to an incongruence between the individual's gender identity and sex assigned at birth.

Gender-Affirming Services	Gender-affirming services mean medical, surgical, mental health, or supportive services provided for the purpose of supporting an individual's gender identity.
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IV. PROCEDURES

A. Information Required for Review:

1. In order for KHS to determine medical necessity for coverage of cosmetic versus reconstructive services, adequate information must be furnished by the treating physician. Necessary documentation includes, but is not limited to, all of the following items when applicable to the indication for use:
 - a. Photographs (anterior and lateral views) of the patient that clearly illustrate the need for the procedure,
 - b. Any test results supporting the need for the procedure,
 - c. Documentation of the following:
 - i. For the purpose of improving/restoring body functions, documentation supporting how the procedure will assist in improving, restoring, or maintaining bodily function as a result of congenital defects, developmental abnormalities, accidental injury/trauma, infection, tumors, or disease;
 - ii. Documentation of specific ADLs (activities of daily living) affected;
 - iii. Records must be kept pursuant with KHS record retention

B. All re-constructive surgery requests to correct a condition which has resulted in a functional defect or has resulted from injury or surgery and has produced a major effect on the Member's appearance will require review by the Medical Director or a physician reviewer.

C. Physician Reviewer Evaluation

1. The reviewing physician may forward the case to a Specialty Advisor for evaluation and determination.

D. The Utilization Management (UM) staff completes the review process and communicates the review decision according to Policy and Procedure 30.92-P Prior Authorization Referrals.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Centers for Medicare and Medicaid Services, Department of Health Care Services, and or Department of Managed Health Care guidance, including applicable All Plan Letters (APLs), Health Plan Management Systems (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	N/A
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VI. REFERENCES

Reference Type	Specific Reference
Regulatory	Health and Safety Code 1367.63 § 422.101 Requirements relating to basic benefits.
Other KHS Policies	30.92-P Prior Authorization Referrals

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New policy created to comply with D-SNP.	UM

VIII. APPROVALS

Committees Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		