SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

All lines of business

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY CRITERIA

Notes:

- The policy criteria below apply to any period of time after mastectomy, lumpectomy, injury, or trauma.
- Other Medical Policies may apply to breast reconstruction services. Please see the Medical Policy Cross References section below for more information.

I. Reconstructive breast surgery may be considered medically necessary and covered when recommended by the treating physician and any of the following (A.-C.) criteria are met:

A. After a prophylactic or therapeutic mastectomy or lumpectomy; or
B. If traumatic injury or surgery of the affected breast results in an asymmetrical change in breast shape or development compared to the contralateral breast; or
C. To correct a congenital or developmental abnormality, which is known to affect normal breast growth. Examples of abnormalities may include, but are not limited to: Poland
syndrome, absence, hypoplasia, unilateral hypertrophy/macromastia, or malformation
of the pectoralis muscles, upper coastal cartilage, or breast.

II. In patients who have a condition noted in criteria I.A-C. above, reconstructive breast
surgery of the unaffected, contralateral breast may be considered **medically necessary and
covered** to achieve symmetry when recommended by the treating physician.

III. Skin substitutes approved by the FDA for breast reconstruction may be considered
**medically necessary** when criteria I. or II. above are met.

IV. Breast surgery is considered cosmetic when used strictly to reshape the breasts to improve
appearance in the absence of a medically necessary indication. Therefore, breast
reconstruction surgery is considered **cosmetic and not covered** if the patient does not
meet any of criteria I.A. – I.C. above.

**CPT CODES**

<table>
<thead>
<tr>
<th>All Lines of Business</th>
<th>Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11920</strong></td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less</td>
</tr>
<tr>
<td><strong>11921</strong></td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm</td>
</tr>
<tr>
<td><strong>11922</strong></td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td><strong>19316</strong></td>
<td>Mastopexy</td>
</tr>
<tr>
<td><strong>19318</strong></td>
<td>Breast reduction</td>
</tr>
<tr>
<td><strong>19324</strong></td>
<td><strong>TERMED 12/31/2020</strong></td>
</tr>
<tr>
<td></td>
<td>Mammaplasty, augmentation; without prosthetic implant</td>
</tr>
<tr>
<td><strong>19325</strong></td>
<td>Breast augmentation with implant</td>
</tr>
<tr>
<td><strong>19328</strong></td>
<td>Removal of intact implant</td>
</tr>
<tr>
<td><strong>19330</strong></td>
<td>Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)</td>
</tr>
<tr>
<td><strong>19340</strong></td>
<td>Insertion of breast implant on same day of mastectomy (ie, immediate)</td>
</tr>
<tr>
<td><strong>19342</strong></td>
<td>Insertion or replacement of breast implant on separate day from mastectomy</td>
</tr>
<tr>
<td><strong>19350</strong></td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td><strong>19355</strong></td>
<td>Correction of inverted nipples</td>
</tr>
<tr>
<td><strong>19357</strong></td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
</tr>
<tr>
<td><strong>19361</strong></td>
<td>Breast reconstruction with latissimus dorsi flap, without prosthetic implant</td>
</tr>
<tr>
<td><strong>19364</strong></td>
<td>Breast reconstruction with free flap</td>
</tr>
<tr>
<td><strong>19366</strong></td>
<td><strong>TERMED 12/31/2020</strong></td>
</tr>
</tbody>
</table>
DESCRIPTION

Breast reconstruction after mastectomy is covered for both the abnormal breast (flap reconstruction or prosthesis) and the normal breast (reduction for symmetry).

Occasionally a lumpectomy (partial mastectomy) necessitates a wide resection and results in deformity of the affected breast. Surgical procedures to correct the defect and to achieve symmetry may be covered.

The medical necessity criteria within this policy are primarily based on the Women’s Health and Cancer Rights Act (WHCRA) of 1998. The WHCRA requires all insurance carriers that cover mastectomies to also cover the following in consultation with the attending physician and patient:

“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, prostheses and treatment of physical complications of the mastectomy, including lymphedema.”

The WHCRA law is not limited to cancer patients or women and applies to anyone who has had a mastectomy.

REVIEW OF EVIDENCE

This policy is primarily based on the Women’s Health and Cancer Rights Act (WHCRA) of 1998. Therefore, an evidence review was not performed.
CLINICAL PRACTICE GUIDELINES

National Comprehensive Cancer Network (NCCN)

In 2020, the NCCN published guidelines for the treatment of breast cancer (Version 6.2020), as part of which investigators addressed the principles of breast reconstruction following surgery. The guideline stated that:

“Breast reconstruction may be an option for any woman receiving surgical treatment for breast cancer. All women undergoing breast cancer treatment should be educated about breast reconstructive options as adapted to their individual clinical situation. However, breast reconstruction should not interfere with the appropriate surgical management of the cancer or the scope of appropriate surgical treatment for this disease...

Surgical options for breast reconstruction following mastectomy include:
- Procedures that incorporate breast implants (ie, tissue expander placement followed by implant placement, immediate implant placement)
- Procedures that incorporate autologous tissue transplantation (ie, pedicled TRAM flap, fat grafting, various microsurgical flaps from the abdomen, back, buttocks, and thigh)
- Procedures that incorporate both breast implants and autologous tissue transplantation (eg, latissimus dorsi flaps).”

CENTERS FOR MEDICARE & MEDICAID

The Centers for Medicare & Medicaid (CMS) National Coverage Determination (NCD140.2) titled: Breast Reconstruction Following Mastectomy, indicates the following:

“Indications and Limitations of Coverage

Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §1862(a)(10) of the Act.)

Additional CMS guidance identified includes the Local Coverage Determination (LCD): Plastic Surgery (L37020) and the Local Coverage Article: Billing and Coding: Plastic Surgery (A57222).

The CMS coverage guideline identified above are in-line with and support the criteria within this policy.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed
annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

MEDICAL POLICY CROSS REFERENCES

- Autologous Fat Transfer
- Breast Implant Removal
- Breast Surgery: Reduction Mammoplasty (All Lines of Business Except Medicare)
- Breast Surgery: Reduction Mammoplasty (Medicare Only)
- Cosmetic and Reconstructive Procedures (All Lines of Business Except Medicare),
- Cosmetic and Reconstructive Procedures (Medicare Only)
- Skin Substitutes
- Surgical Treatments for Lymphedema

REFERENCES
