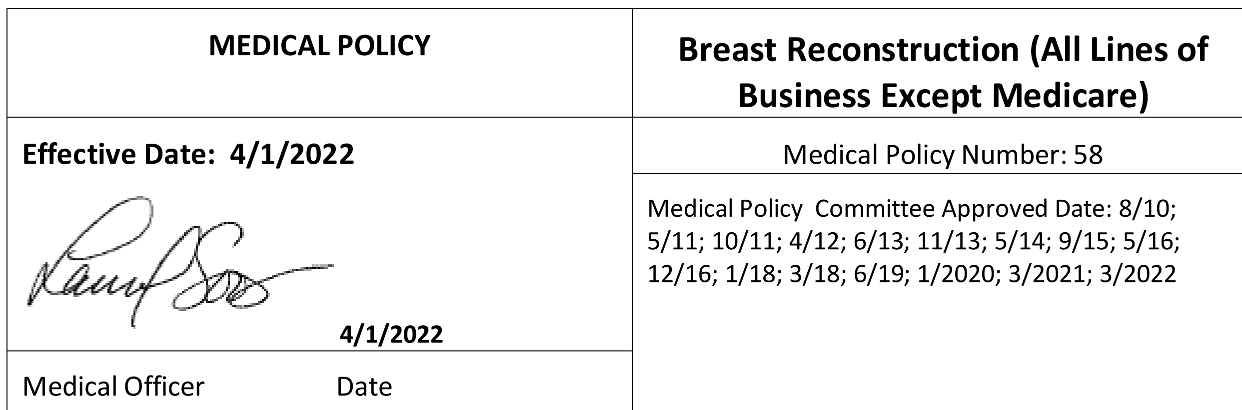

MEDICAL POLICY	Breast Reconstruction (All Lines of Business Except Medicare)
Effective Date: 4/1/2022	Medical Policy Number: 58
4/1/2022	Medical Policy Committee Approved Date: 8/10; 5/11; 10/11; 4/12; 6/13; 11/13; 5/14; 9/15; 5/16; 12/16; 1/18; 3/18; 6/19; 1/2020; 3/2021; 3/2022
Medical Officer Date	

See Policy CPT CODE section below for any prior authorization requirements

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 except Medicare

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 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

All Lines of Business Except Medicare	
Prior Authorization Required	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	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)
19316	Mastopexy
19318	Breast reduction
~~19324~~	**TERMED 12/31/2020** ~~Mammaplasty, augmentation; without prosthetic implant~~
19325	Breast augmentation with implant
19328	Removal of intact implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364	Breast reconstruction with free flap
~~19366~~	**TERMED 12/31/2020** ~~Breast reconstruction with other technique~~
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
No Prior Authorization Required	
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis

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:[1]

> "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."[2]

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 2022, the NCCN published guidelines for the treatment of breast cancer (Version 2.2022), as part of which investigators addressed the principles of breast reconstruction following surgery.[3] 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)."[3]

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)
- Breast Reconstruction (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

1. Centers for Medicare & Medicaid Services. The Center for Consumer Information & Insurance Oversight: Women's Health and Cancer Rights Act (WHCRA). https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet. Published 2013. Accessed 2/18/2022.
2. U.S. Department of Labor - Employee Benefits Security Administration. FAQs about Women's Health and Cancer Rights. https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/whcra.pdf. Accessed 2/18/2022.
3. National Comprehensive Cancer Network (NCCN). Breast Cancer. NCCN Evidence Blocks. Version 2.2022. Published 2022. https://www.nccn.org/professionals/physician_gls/pdf/breast_blocks.pdf. Accessed 2/20/2022.