

BREAST REPAIR/RECONSTRUCTION NOT FOLLOWING MASTECTOMY

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Related Commercial Policies	
<ul style="list-style-type: none"> • Breast Reconstruction Post Mastectomy • Breast Reduction Surgery • Cosmetic and Reconstructive Procedures • Gender Dysphoria Treatment 	
Community Plan Policy	
<ul style="list-style-type: none"> • Breast Repair/Reconstruction Not Following Mastectomy 	

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Coverage Determination Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

If the member’s condition meets the Women’s Health and Cancer Rights Act (WHCRA) criteria, refer to the Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy](#).

Criteria for a Coverage Determination as Reconstructive

Removal of breast implants with capsulectomy/capsulotomy for symptomatic capsular contracture is considered reconstructive when the following criteria are met:

- Baker grade III or IV capsular contracture
 - *Baker Grading System for Capsular Contracture:*
 - Grade I – Breast is soft without palpable thickening
 - Grade II – Breast is a little firm but no visible changes in appearance
 - Grade III – Breast is firm and has visible distortion in shape
 - Grade IV – Breast is hard and has severe distortion or malposition in shape; pain/discomfort may be associated with this level of capsule contracture (ASPS, 2005)
- Limited movement leading to an inability to perform tasks that involve reaching or abduction. Examples include retrieving something from overhead, combing one's hair, reaching out or above to grab something to stabilize oneself.

Removal of a deflated saline breast implant shell is considered cosmetic unless the implants were done post mastectomy. (See Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy](#).)

Correction of inverted nipples is considered reconstructive when one of the following criteria are met:

- Member meets the Women's Health and Cancer Rights Act (WHCRA) criteria (see Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy](#) for details); or
- Documented history of chronic nipple discharge, bleeding, scabbing or ductal infection.

Note: Correction of congenital inverted nipples may be covered based on a state mandate or the member specific benefit plan document. See the definition of [Congenital Anomaly](#) below.

Breast reconstruction performed to treat [Poland Syndrome](#) (see definition below) is reconstructive.

Although no Functional Impairment may exist for the breast reconstruction to treat Poland Syndrome, this has been deemed reconstructive surgery.

Removal of a ruptured silicone gel breast implant is covered regardless of the indication for the initial implant placement.

Removal of a breast implant and capsulectomy is covered, regardless of the indication for the initial implant placement, for treatment of anaplastic lymphoma of the breast when there is pathologic confirmation of the diagnosis by cytology or biopsy.

Additional Information

Tissue protruding at the end of a scar ("dog ear"/standing cone), painful scars or donor site scar revisions must be reviewed to determine if the procedure meets reconstructive guidelines.

Coverage Limitations and Exclusions

Some states require coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to the member specific benefit plan document.

- Cosmetic Breast Procedures are excluded from coverage. Examples include, but are not limited to:
 - Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy; see the Coverage Determination Guideline titled [Breast Reconstruction Post Mastectomy](#).)
 - Breast reduction surgery that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or is related to coverage required by the Women's Health and Cancer Right's Act.
 - Breast surgery only for the purpose of creating symmetrical breasts except when post mastectomy.
 - Breast prosthetics or replacement following a cosmetic breast augmentation.
- Revision of a prior reconstructed breast due to normal aging does not meet the definition of a covered reconstructive health service.

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Anaplastic Lymphoma: Breast implant–associated (BIA) anaplastic large cell lymphoma (ALCL) is a rare T-cell lymphoma that can present as a delayed fluid collection around a textured implant or surrounding scar capsule.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Congenital Anomaly (California only): A physical developmental defect that is present at birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Cosmetic Procedures (California only): Procedures or services that are performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance.

Functional or Physical Impairment: A physical or functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Poland Syndrome: Poland syndrome is a congenital absence of the pectoralis major muscle, usually the sternal component, as well as breast and areolar hypoplasia. This condition can also be associated with absence of the latissimus dorsi and serratus anterior muscles, hand symbrachydactyly, and other extremity deformities.

Reconstructive Procedures: Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Reconstructive Procedures (California only): Reconstructive Procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function
- To create a normal appearance, to the extent possible

Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

Sickness: Physical illness, disease or Pregnancy. The term Sickness includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19355	Correction of inverted nipples
19370	Open periprosthetic capsulotomy, breast

CPT Code	Description
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast

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REFERENCES

American Society of Plastic Surgeons (ASPS). Practice Parameter. Treatment Principles of Silicone Breast Implants. March 2005. Available at: <http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/TreatmentPrinciplesofSiliconeBreastImplants.pdf>. Accessed August 29, 2018.

American Society of Plastic Surgeons (ASPS). How to Diagnose and Treat Breast Implant– Associated Anaplastic Large Cell Lymphoma.

Jones Glyn E. Bostwick’s Plastic & Reconstructive Breast Surgery, 3rd ed. Quality Medical Publishing, Inc 2010.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2001.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2007.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2011.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
02/12/2019	<ul style="list-style-type: none"> Corrected formatting error in coverage rationale (no change to content/language)
01/01/2019	<ul style="list-style-type: none"> Updated coverage rationale; removed duplicative language pertaining to the diagnosis of anaplastic lymphoma (no change to guidelines) Archived previous policy version CDG.005.07