Breast Reconstruction Following Mastectomy

Policy Number: MCS011.01
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Instructions for Use

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Related Medicare Advantage Policy Guidelines

- Breast Reconstruction Following Mastectomy (NCD 140.2)
- Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)
- Pneumatic Compression Devices (NCD 280.6)

Coverage Guidelines

Breast reconstruction post mastectomy is covered when Medicare coverage criteria are met.

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. Refer to the National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2). (Accessed March 22, 2021)

When a member elects breast reconstruction following a medically necessary mastectomy or lumpectomy, coverage in accordance with Medicare guidelines is to be provided as determined through consultation between the attending physician and the member. Refer to the Women's Health and Cancer Rights Act (WHCRA). (Accessed March 22, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the table for Breast Implant and Tissue Expansion.

Covered services include, but are not limited to:

- External breast prosthesis and bras; refer to the Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.
- Breast Implant and Tissue Expansion (CPT codes 19340, 19342, 19357)
  - Medicare does not have an NCD for breast implant and tissue expansion. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the table for Breast Implant and Tissue Expansion.
  - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline for Breast Reconstruction Post Mastectomy and Poland Syndrome for coverage guideline.
    Note: After checking the Breast Implant and Tissue Expansion table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
- Nipple tattoo for post-mastectomy reconstructive purposes; refer to the Coverage Summary titled Cosmetic and Reconstructive Procedure.
- Adjacent tissue transfer; refer to the Coverage Summary titled Cosmetic and Reconstructive Procedure.
- Mastopexy; refer to the Coverage Summary titled Cosmetic and Reconstructive Procedure.
- Reductive mammoplasty; refer to the Coverage Summary titled Cosmetic and Reconstructive Procedure.

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- Pneumatic compression devices are covered for the treatment of physical complications resulting from the mastectomy or lumpectomy, including lymphedema. Refer to the Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.
- Myocutaneous flaps (CPT codes 19361, 19364, 19367, 19368, 19369)
  - Medicare does not have an NCD for myocutaneous flaps. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the table for Myocutaneous Flaps.
  - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline for Breast Reconstruction Post Mastectomy and Poland Syndrome for coverage guideline.
    Note: After checking the Myocutaneous Flaps table and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Reconstructive services are not covered for members who have not had a medically necessary mastectomy or lumpectom18y and who are requesting surgery only for the purpose of creating symmetrical breasts or other cosmetic purpose.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §l862(a)(l0) of the Act). Refer to the NCD for Breast Reconstruction Following Mastectomy (140.2). (Accessed March 22, 2021)

Note: On July 24, 2019, the Food and Drug Administration (FDA) issued a safety communication related to the voluntary recall of certain Allergan BIOCELL textured breast implants and tissue expanders. For specific information, refer to the following FDA communication at: https://www.fda.gov/medical-devices/safety-communications/fda-requests-allergan-voluntarily-recall-natrelle-biocell-textured-breast-implants-and-tissue. (Accessed March 22, 2021)

For guidelines on services related to and required as a result of services which are not covered under Medicare. Refer to the Coverage Summary titled Non-Covered Services (Including Services/Complicated Related to Non-Covered Services).

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Breast Implant and Tissue Expansion (CPT codes 19340, 19342 and 19357)
Myocutaneous Flaps (CPT codes 19361, 19364, 19367, 19368 and 19369)
Accessed November 9, 2021

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L35163 (A57221)	Plastic Surgery	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA, GU, HI, MP, NV
L37020 (A57222)	Plastic Surgery	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L35090 (A56687)	Cosmetic and Reconstructive Surgery	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L33428 (A56658)	Cosmetic and Reconstructive Surgery	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV,
L39051 (A58774)	Cosmetic and Reconstructive Surgery	Part A MAC	Wisconsin Physicians Service Insurance Corp.	AK*, AL*, AR*, AZ*, CA*, CO*, CT, DE*, FL, GA*, HI*, IA, ID*, IL, IN, KS, KY, LA*, MA, MD*, ME, MI, MO, MS*, MT*, NC*, ND*, NE, NH, NJ*, NM*, NV*, OH, OK*, OR, PA*, RI,

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Breast Implant and Tissue Expansion (CPT codes 19340, 19342 and 19357) Myocutaneous Flaps (CPT codes 19361, 19364, 19367, 19368 and 19369) Accessed November 9, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
				SC*, SD*, TN*, TX*, UT*, VA*, VT, WA*, WI, WV*, WY Note: States notated with an asterisk should follow the other available state-specific LCD/LCA listed in this table. This WPS LCD/LCA only applies to states without asterisk.
L39051 (A58774)	Cosmetic and Reconstructive Surgery	Part B MAC	Wisconsin Physicians Service Insurance Corp.	IA, IN, KS, MI, MO, NE
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Policy History/Revision Information

Date	Summary of Changes

04/20/2021	**Template Update**
	• Reformatted policy; transferred content to new template
	Coverage Guidelines
	Myocutaneous Flaps (CPT codes 19361, 19364, 19367, 19368, and 19369)
	• Updated list of applicable CPT codes; removed 19366
	Definitions
	• Removed definition of:
	  ○ Mastectomy
	  ○ Reconstructive Surgery

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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