## Coverage Summary

### Breast Reconstruction Following Mastectomy

**Policy Number:** B-004  
**Products:** UnitedHealthcare Medicare Advantage Plans  
**Original Approval Date:** 02/09/2007  
**Approved by:** UnitedHealthcare Medicare Benefit Interpretation Committee  
**Last Review Date:** 08/20/2019

### 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)

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**Coverage Statement:** Breast reconstruction post mastectomy is covered when Medicare coverage criteria are met.

**Guidelines/Notes:**

1. 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. See the NCD for Breast Reconstruction Following Mastectomy (140.2). (Accessed March 26, 2019)

   When a memberelects 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. See the Women's Health and Cancer Rights Act (WHCRA). (Accessed March 26, 2019)
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 LCD Availability Grid (Attachment A). (Accessed October 24, 2019)

Covered services include, but are not limited to:

a. External breast prosthesis and bras; see the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.

b. Breast Implant and Tissue Expansion (CPT codes 19340, 19342, 19357)
   - Medicare does not have a National Coverage Determination (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 LCD Availability Grid (Attachment A).
   - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline for Breast Reconstruction Post Mastectomy for coverage guideline.
   - (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: April 16, 2019
   - Accessed October 24, 2019

c. Nipple tattoo for post-mastectomy reconstructive purposes; see the Coverage Summary for Cosmetic and Reconstructive Procedure.

d. Adjacent tissue transfer; see the Coverage Summary for Cosmetic and Reconstructive Procedure.

e. Mastopexy; see the Coverage Summary for Cosmetic and Reconstructive Procedure.

f. Reductive Mammoplasty; see the Coverage Summary for Cosmetic and Reconstructive Procedure.

g. Pneumatic compression devices are covered for the treatment of physical complications resulting from the mastectomy or lumpectomy, including lymphedema. See the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.

h. Myocutaneous Flaps (CPT codes 19361, 19364, 19366, 19367, 19368, 19369)
   - Medicare does not have a National Coverage Determination (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 LCD Availability Grid (Attachment A).
   - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline for Breast Reconstruction Post Mastectomy for coverage guideline.
   - (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: April 16, 2019
   - Accessed October 24, 2019
2. Reconstructive services are not covered for members who have not had a medically necessary mastectomy or lumpectomy 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 §1862(a)(10) of the Act). See the NCD for Breast Reconstruction Following Mastectomy (140.2). (Accessed March 26, 2019)

**Note:**

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

**II. DEFINITIONS**


**III. REFERENCES**

See above
IV. REVISION HISTORY

08/20/2019  Guideline 2 (Non-covered Reconstructive Services)
- Added notation to indicate:
  - 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, see the following FDA communication at https://www.fda.gov/news-events/press-announcements/fda-takes-action-protect-patients-risk-certain-textured-breast-implants-requests-allergan?utm_campaign=072419_PR_FDA%20requests%20Allergan%20voluntarily%20recall%20certain%20breast%20implants%20from%20market&utm_medium=email&utm_source=Eloqua.
  - For guidelines on services related to and required as a result of services which are not covered under Medicare, see the UnitedHealthcare Medicare Advantage Coverage Summary titled Non-Covered Services (Including Services/Complicated Related to Non-Covered Services)
- Updated Local Coverage Determination (LCD) Availability Grid to reflect the most current reference links

V. ATTACHMENT

Attachment A - LCD Availability Grid

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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<td>L34698</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>Mac Part A</td>
<td>Wisconsin Physicians Service</td>
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</tr>
<tr>
<td>L34698</td>
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<td>Mac Part B</td>
<td>Wisconsin Physicians Service</td>
<td>IA, IN, KS, MI, MO, NE</td>
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<tr>
<td>L33428</td>
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<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV, AL, GA, TN</td>
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<td>L35090</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY</td>
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</tbody>
</table>

CMS website accessed October 24, 2019

End of Attachment A