Coverage Summary

Breast Reconstruction Following Mastectomy

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<tbody>
<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 04/21/2020</td>
</tr>
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</table>

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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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 is 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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I. COVERAGE

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 30, 2020)

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. See the Women's Health and Cancer Rights Act (WHCRA). (Accessed March 30, 2020)
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/LCA Availability Grid (Attachment A).

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/LCA Availability Grid (Attachment A).
   - 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. (IMPORTANT NOTE: After checking the LCD/LCA 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 21, 2020
   - Accessed January 5, 2021

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 Mammaplasty; 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/LCA Availability Grid (Attachment A).
   - 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. (IMPORTANT NOTE: After checking the LCD/LCA 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 21, 2020
   - Accessed January 5, 2021

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 30, 2020)

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, 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. (Accessed March 30, 2020)

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

IV. REVISION HISTORY

04/21/2020  •  Routine review; no change to coverage guidelines

V. ATTACHMENT

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<thead>
<tr>
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<th>Title</th>
<th>Contractor Type</th>
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<th>States</th>
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<td>Plastic Surgery</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
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<td>L37020</td>
<td>Plastic Surgery</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
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<td>L35090</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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Attachment A – LCD/LCA Availability Grid

**Breast Implant and Tissue Expansion**
(CPT codes 19340, 19342 and 19357)

**Myocutaneous Flaps**
(CPT codes 19361, 19364, 19366, 19367, 19368 and 19369)

CMS website accessed January 5, 2021
## Attachment A – LCD/LCA Availability Grid

### Breast Implant and Tissue Expansion
(CPT codes 19340, 19342 and 19357)

### Myocutaneous Flaps
(CPT codes 19361, 19364, 19366, 19367, 19368 and 19369)

CMS website accessed January 5, 2021

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<td>L34698</td>
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<td>Mac Part B</td>
<td>Wisconsin Physicians Service Ins Corp.</td>
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(Note: States notated with an asterisk should follow the other available state-specific LCD/LCA listed on this grid. This WPS LCD/LCA only applies to states without asterisk.)

End of Attachment A