# Coverage Summary

## Breast Reconstruction Following Mastectomy

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<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date:</td>
<td>09/18/2018</td>
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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)

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This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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.

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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 April 5, 2018)

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 April 5, 2018)

**Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs,**
Covered services include, but are not limited to:

a. External breast prosthesis and bras; see the 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 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 17, 2018
   • Accessed October 2, 2018

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

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

e. Mastopexy; see the Cosmetic and Reconstructive Procedures Coverage Summary.

f. Reductive Mammaplasty; see the Cosmetic and Reconstructive Procedures Coverage Summary.

g. Pneumatic compression devices are covered for the treatment of physical complications resulting from the mastectomy or lumpectomy, including lymphedema. See the 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 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 17, 2018
   • Accessed October 2, 2018

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.
II. DEFINITIONS

**Mastectomy:** The surgical removal of part or all of the breast, and sometimes other tissue. *American Cancer Society, Glossary of Terms; available at http://www.cancer.org/Cancer/CancerGlossary/index. (Accessed April 5, 2018)*


III. REFERENCES

See above

IV. REVISION HISTORY

09/18/2018 Updated Local Coverage Determination (LCD) Availability Grid; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

04/17/2018 Annual review with the following updates:

Guideline 1 - updated to include the following coverage language from the reference NCD for Breast Reconstruction Following Mastectomy (140.2):

*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.*

Guideline 1.a – deleted the following; will be included under Guideline 1

*Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy.*

Guideline 1.c [Initial breast implant (CPT code 19340)] – moved and included under new Guideline 1.b (Breast Implant and Tissue Expansion)

Guideline 1.d (Replacement breast implants when medically necessary) – moved and included under new Guideline 1.b (Breast Implant and Tissue Expansion)

Guideline 1.b [Breast Implant and Tissue Expansion (CPT codes 19340, 19339, 19342, 19357)] – added detailed guideline

Guideline 1.e [Nipple Tattoo (CPT codes 11920, 11921, 11922)] – deleted CPT codes; guideline has cross reference link to the Cosmetic and Reconstructive Procedures Coverage Summary which includes guideline and CPT codes for Nipple Tattoo.

Guideline 1.f [Tissue expansion (CPT code 19357)] – moved and included under new Guideline 1.b (Breast Implant and Tissue Expansion)
Guideline 1.g (Regional Tissue Transfer) – changed to “Adjacent Tissue Transfer” and add cross reference link to the Cosmetic and Reconstructive Procedures Coverage Summary.

Guideline 1.h [Mastopexy (CPT code 19316)] - deleted CPT codes; guideline has cross reference link to the Cosmetic and Reconstructive Procedures Coverage Summary which includes guideline and CPT codes for Mastopexy.

Guideline 1.i [Reductive Mammaplasty)(CPT code 19318)] - deleted CPT codes; guideline has cross reference link to the Cosmetic and Reconstructive Procedures Coverage Summary which includes guideline and CPT codes for Reductive Mammaplasty.

Guideline 1.j (Pneumatic Compression Devices)
- Deleted the following language (already in the DME Grid)

  *LCDs exist and compliance with these policies is required where applicable. See the LCD for Pneumatic Compression Devices (L33829).*

DME Face to Face Requirement: Effective July 1, 2013, Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including pneumatic compression devices). For DME Face to Face Requirement information, refer to the Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid

- Revised guideline to read:

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

Guideline 2 – updated to include the following language update to include the following coverage language from the reference NCD for Breast Reconstruction Following Mastectomy (140.2):

  *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.)*

01/16/2018 Re-review with the following updates:

Guideline 1 - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 1.k (Myocutaneous Flaps) - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

04/18/2017 Annual review with the following updates:

Guideline 1.k [Myocutaneous Flaps (CPT codes 19361, 19364, 19366, 19367, 19368, 19369)]

• Deleted the reference link to the UnitedHealthcare Coverage Determination Guideline for Cosmetic and Reconstructive Procedures

03/21/2017 Re-review with the following update:
• Guideline 1.k (Myocutaneous Flaps) - Updated reference from MCG 20th to the 21st edition 2017.

03/15/2016 Annual review with the following updates:
• Guideline 1.k (Myocutaneous Flaps) - Updated reference from MCG 19th to the 20th edition.
• Updated reference link(s) of the applicable LCDs in the Availability Grids to reflect the condensed link.

12/16/2015 Updated the LCD Availability Grid to include reference link(s) to the applicable LCDs to reflect the new LCD ID numbering effective October 1, 2015 and December 10, 2015.

5/19/2015 Annual review with the following update:
Guideline 1.k (Myocutaneous Flaps) - Changed default policy for states with no LCDs from UnitedHealthcare Coverage Determination Guideline for Breast Reconstruction Post Mastectomy to MCG™ Care Guidelines, 19th edition, 2015, Mastectomy, Complete, with Tissue Flap Reconstruction ORG:S-864 (ISC)

05/20/2014 Annual review with the following updates:
• Guideline #1.j (Breast Reconstruction with Latissimus Dorsi Flap) – Deleted; already addressed under Guideline #1.k Myocutaneous Flaps.
• Definitions - Updated definition of Reconstructive Surgery.

02/18/2014 Guidelines #1.k.2 (Complex Decongestive Physiotherapy) – section deleted; default LCD, L32698 was retired on October 31, 2013.

08/20/2013 Added a note pertaining to the DME Face-to-Face Requirement in accordance with Section 6407 of the Affordable Care Act as defined in the 42 CFR 410.38(g).
Guidelines #1.1 (Myocutaneous Flaps)-Added applicable coverage guidelines (new to policy). Added reference to CPT codes 19361, 19364, 19366, 19367, 19368 and 19369.

06/24/2013 Annual review with the following updates:
• Guidelines #1.e (Nipple tattoo for post-mastectomy reconstructive purposes) - Guidelines replaced with the link to the Cosmetic and Reconstructive Procedures Coverage Summary.
• Guidelines #1.f (Tissue expansion) - Added reference to CPT code 19357
• Guidelines #1.h (Mastopexy) - Guidelines replaced with the link to the Cosmetic and Reconstructive Procedures Coverage Summary.
• Guideline #1.i (Reductive Mammaplasty) - Guidelines replaced with the link to the Cosmetic and Reconstructive Procedures Coverage Summary
Guidelines #1.j (Breast reconstruction with Latissimus Dorsi flap) - Added under covered services (new to policy)

Guideline #2 (Breast reconstruction with muscle or myocutaneous flap; CPT code 19360) - Guidelines deleted; guidelines and CPT code 19360 no longer addressed in the Medicare Claims Manual.

06/18/2012  Annual review; no updates.
12/02/2011  Updated LCD Availability Grid (Attachment A), added Trailblazer L31784 and Palmetto L30852.
01/19/2011  Policy updated to include the new web site for the American Cancer Society, Glossary of Terms in the Reference section.

## V. ATTACHMENT(S)

### Attachment A - LCD Availability Grid

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

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

CMS website accessed October 2, 2018

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<td>Wisconsin Physicians Service</td>
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End of Attachment A