BREAST RECONSTRUCTION FOLLOWING MASTECTOMY
(NCD 140.2)

Guideline Number: MPG034.04  Approval Date: January 9, 2019

Table of Contents

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY SUMMARY</td>
</tr>
<tr>
<td>APPLICABLE CODES</td>
</tr>
<tr>
<td>PURPOSE</td>
</tr>
<tr>
<td>REFERENCES</td>
</tr>
<tr>
<td>GUIDELINE HISTORY/REVISION INFORMATION</td>
</tr>
<tr>
<td>TERMS AND CONDITIONS</td>
</tr>
</tbody>
</table>

POLICY SUMMARY

Overview
There has been a considerable change in the treatment of diseases of the breast such as fibrocystic disease and cancer. While extirpation of the disease remains of primary importance, the quality of life following initial treatment is increasingly recognized as of great concern. The increased use of breast reconstruction procedures is due to several factors:

- A change in epidemiology of breast cancer, including an apparent increase in incidence;
- The continuing development of better prostheses;
- Improved surgical skills and techniques; and
- Increasing awareness by physicians of the importance of postsurgical psychological adjustment.

Guidelines
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.

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.)

APPLICABLE CODES

The following list(s) of 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 Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19328</td>
<td>Removal of intact mammary implant</td>
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<tr>
<td>19330</td>
<td>Removal of mammary implant material</td>
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<tr>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction (See also NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery)</td>
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<tr>
<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction (See also NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery)</td>
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CPT Code | Description
--- | ---
19350 | Nipple/areola reconstruction (See also NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery)
19357 | Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361 | Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364 | Breast reconstruction with free flap
19366 | Breast reconstruction with other technique
19367 | Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), single pedicle, including closure of donor site;
19368 | Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369 | Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), double pedicle, including closure of donor site
19370 | Open periprosthetic capsulotomy, breast
19371 | Periprosthetic capsulectomy, breast
19380 | Revision of reconstructed breast
19396 | Preparation of moulage for custom breast implant

Modifier | Description
--- | ---
50 | Bilateral procedure
LT | Left side (used to identify procedures performed on the left side of the body)
RT | Right side (used to identify procedures performed on the right side of the body)

PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:
- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 140.2 Breast Reconstruction Following Mastectomy

CMS Local Coverage Determinations (LCDs)
Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<tr>
<th>Date</th>
<th>Action/Description</th>
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</thead>
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<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
<tr>
<td>01/09/2019</td>
<td>• Annual review</td>
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<tr>
<td></td>
<td>• Question and Answer section removed</td>
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</tbody>
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**TERMS AND CONDITIONS**

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

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 member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member’s benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.