Breast Repair/Reconstruction Not Following Mastectomy

Guideline Number: CS013.M
Effective Date: December 1, 2021

Instructions for Use

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Application

This Coverage Determination Guideline does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Breast Repair/Reconstruction Not Following Mastectomy (for Indiana Only)
Kentucky	Breast Repair/Reconstruction Not Following Mastectomy (for Kentucky Only)
Louisiana	Breast Repair/Reconstruction Not Following Mastectomy (for Louisiana Only)
Mississippi	Breast Repair/Reconstruction Not Following Mastectomy (for Mississippi Only)
Nebraska	Breast Repair/Reconstruction Not Following Mastectomy (for Nebraska Only)
New Jersey	Breast Repair/Reconstruction Not Following Mastectomy (for New Jersey Only)
North Carolina	Breast Repair/Reconstruction Not Following Mastectomy (for North Carolina Only)
Pennsylvania	Breast Repair/Reconstruction Not Following Mastectomy (for Pennsylvania Only)
Tennessee	Breast Repair/Reconstruction Not Following Mastectomy (for Tennessee Only)

Coverage Rationale

Indications for Coverage

The following are eligible for coverage as Reconstructive and medically necessary:

- Correction of inverted nipples is considered reconstructive when one of the following criteria are met:
  - Documented history of chronic nipple discharge, bleeding, scabbing or ductal infection; or
  - For correction of an inverted nipple(s) resulting from a Congenital Anomaly
- Anaplastic Lymphoma of the breast:
  - Removal of a breast implant and capsulectomy is covered, regardless of the indication for the initial implant placement, for:

    - Treatment of Anaplastic Lymphoma of the breast when there is pathologic confirmation of the diagnosis by cytology or biopsy; or
    - For individuals with an increased risk of implant-associated Anaplastic Lymphoma of the breast due to use of Allergan BIOCELL textured breast implants and tissue expanders
- Removal of a deflated saline breast implant shell when the implants were done post mastectomy (refer to the Coverage Determination Guideline titled Breast Reconstruction Post Mastectomy and Poland Syndrome)
- Removal of a ruptured silicone gel breast implant regardless of the indication for the initial implant placement

Note: Refer to the Coverage Determination Guideline titled Breast Reconstruction Post Mastectomy and Poland Syndrome for coverage information regarding Poland Syndrome.

Removal of breast implants with capsulectomy/capsulotomy for symptomatic capsular contracture is considered reconstructive when the following criteria are met:

- Baker grade III or IV capsular contracture
  Baker Grading System for Capsular Contracture
    - *Grade I* – Breast is soft without palpable thickening
    - *Grade II* – Breast is a little firm but no visible changes in appearance
    - *Grade III* – Breast is firm and has visible distortion in shape
    - *Grade IV* – Breast is hard and has severe distortion or malposition in shape; pain/discomfort may be associated with this level of capsule contracture (ASPS, 2005)
- Limited movement leading to an inability to perform tasks that involve reaching or abduction; examples include retrieving something from overhead, combing one's hair, reaching out or above to grab something to stabilize oneself

The breast reconstruction benefit does not include coverage for any of the following:

- Aspirations
- Biopsy (open or core)
- Excision of cysts
- Fibroadenomas or other benign or malignant tumors
- Aberrant breast tissue
- Duct lesions
- Nipple or areolar lesions
- Treatment of gynecomastia

Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Breast prosthetics or replacement following a cosmetic breast augmentation.
- Breast reduction surgery when done to improve appearance without improving a Functional/Physiologic Impairment.
- Breast surgery only for the purpose of creating symmetrical breasts except when post mastectomy.
- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. Refer to the Coverage Determination Guideline titled Breast Reconstruction Post Mastectomy and Poland Syndrome.)
- Revision of a prior reconstructed breast due to normal aging does not meet the definition of a covered reconstructive health service.
- Tissue protruding at the end of a scar ("dog ear"/standing cone), painful scars or donor site scar revisions must meet the definition of a reconstructive procedure to be considered for coverage.

Definitions

Check the definitions within the member benefit plan document that supersede the definitions below.

Anaplastic Lymphoma: Breast implant-associated (BIA) anaplastic large cell lymphoma (ALCL) is a rare T-cell lymphoma that can present as a delayed fluid collection around a textured implant or surrounding scar capsule.

Congenital Anomaly: A physical developmental defect that is present at the time of birth and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Functional or Physical Impairment: A Functional or Physical or physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:
- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Sickness: Physical illness, disease or pregnancy. The term sickness includes mental illness or substance-related and addictive disorders, regardless of the cause or origin of the mental illness or substance-related and addictive disorders.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy 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 federal, state, or contractual requirements 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.

CPT Code	Description
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)
19355	Correction of inverted nipples
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)

References

American Society of Plastic Surgeons (ASPS). How to Diagnose and Treat Breast Implant – Associated Anaplastic Large Cell Lymphoma.

American Society of Plastic Surgeons (ASPS). Practice Parameter. Treatment Principles of Silicone Breast Implants. March 2005. Available at: http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/TreatmentPrinciplesofSiliconeBreastImplants.pdf. Accessed August 25, 2021.

Jones Glyn E. Bostwick's Plastic & Reconstructive Breast Surgery, 3rd ed. Quality Medical Publishing, Inc. 2010.

United States Food and Drug Administration (FDA), The FDA Takes Action to Protect Patients from Risk of Certain Textured Breast Implants; Requests Allergan Voluntarily Recall Certain Breast Implants and Tissue Expanders from the Market: FDA Safety Communication. Available at: https://www.fda.gov/medical-devices/safety-communications/fda-takes-action-protect-patients-risk-certain-textured-breast-implants-requests-allergan. Accessed August 25, 2021.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Guideline History/Revision Information

Date	Summary of Changes
12/01/2021	**Related Policies** • Added reference link to the Coverage Determination Guideline titled *Gynecomastia Treatment* **Coverage Rationale** ***Coverage Limitations and Exclusions*** • Removed reference to the *Women's Health and Cancer Right's Act* **Supporting Information** • Archived previous policy version CS013.L

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.