

Breast Repair/Reconstruction Not Following Mastectomy (for Indiana Only)

Guideline Number: CS013IN.01
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[Instructions for Use](#)

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Related Policies
• Breast Reconstruction Post Mastectomy and Poland Syndrome
• Breast Reduction Surgery
• Cosmetic and Reconstructive Procedures
• Gender Dysphoria Treatment

Application

This Coverage Determination Guideline only applies to the state of Indiana.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the [Indiana Surgical Services Provider Reference Module](#).

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 (eg, 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 (eg, 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)

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Guideline History/Revision Information

Date	Summary of Changes
04/01/2021	<ul style="list-style-type: none"><li data-bbox="337 222 837 249">• New Coverage Determination Guideline

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.