Breast Reconstruction Post Mastectomy and Poland Syndrome (for Tennessee Only)

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Instructions for Use

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Commercial Policy

- Breast Reconstruction Post Mastectomy and Poland Syndrome

Application

This Coverage Determination Guideline applies to Medicaid only plans in the state of Tennessee.

Coverage Rationale

Indications for Coverage

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

- The following services are covered (with or without a diagnosis of cancer):
  - Reconstruction of the breast on which the Mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance, including nipple tattooing
  - Prosthesis (implanted and/or external)
  - Treatment of physical complications of Mastectomy, including lymphedema
  - Treatment of Poland Syndrome with breast reconstruction; this is considered reconstructive surgery although no Functional Impairment may exist

Removal, replacement, or revision of an implant may be considered reconstructive in certain circumstances:

- When the original implant or reconstructive surgery was considered reconstructive surgery under the terms of the member's benefit plan, coverage may exist for removal, replacement, and/or reconstruction
- When the original implant or reconstructive surgery was considered reconstructive surgery under the terms of the member's benefit plan, then removal of a ruptured prosthesis is treating a "complication arising from a medical or surgical intervention"
- Removal of a breast implant and capsulectomy is covered, regardless of the indication for the initial implant placement, for the following:
  - Treatment of Anaplastic Lymphoma of the breast when there is pathologic confirmation of the diagnosis by cytology or biopsy; or
  - 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
- Revision of a reconstructed breast (CPT code 19380) when the original reconstruction was performed following mastectomy or for another covered health service (see Applicable Codes section below for a list of codes that meet the criteria for a reconstructed breast)

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

Breast Reconstruction

The following procedures may be utilized during breast reconstruction:

- A woman's own muscle, fat and skin are repositioned to create a breast mound by one of the following methods:
  - Transverse Rectus Abdominus Myocutaneous (TRAM) Flap – The muscle, fat and skin from the lower abdomen is used to reconstruct the breast
  - Deep Inferior Epigastric Perforator (DIEP) or Superior Gluteal Artery Perforator SGAP Flap – The fat and skin but not muscle is used from the lower abdomen or buttocks to reconstruct the breast
  - Latissimus Dorsi (LD) Flap – The muscle, fat and skin from the back are used to reconstruct the breast – may also need a breast implant
  - Other methods may also be used to move muscle, fat and skin to reconstruct a breast
- Tissue expansion is used to stretch the skin and tissue to provide coverage for a breast implant to create a breast mound. The procedure can be done with or without a dermal matrix including but not limited to Alloderm, Allomax, DermACELL, or FlexHD which are a covered benefit. Note: Reconstruction alone may be done with an implant, but a tissue expander may be needed.
  - Tissue expansion requires several office visits over 4-6 months to fill the device through an internal valve to expand the skin
- After the tissue expansion is completed, surgical placement of an FDA approved breast implant (either silicone or saline) is performed. The breast implant may be used with a flap or alone following tissue expansion.
- After the breast implant is completed, creation of a nipple (by various techniques) and areola (tattooing) may be performed
- Mastopexy or breast reduction when required prior to mastectomy to preserve the viability of the nipple
- Autologous fat transplant (including the harvesting of fat and the injection)

Treatments for Complications Post Mastectomy

- Lymphedema:
  - Complex decongestive physiotherapy (CDP) is covered for the complication of lymphedema post Mastectomy
  - Lymphedema pumps when required are covered (when covered, these pumps are covered as Durable Medical Equipment)
  - Compression lymphedema sleeves are covered (when covered, these sleeves are covered as a prosthetic device)

    - Elastic bandages and wraps associated with covered treatments for the complications of lymphedema
- Treatment of a post-operative infection(s)
- Removal of a ruptured breast implant (either silicone or saline) is reconstructive for implants done post Mastectomy; placement of a new breast implant will be covered if the original implantation was done post Mastectomy or for a covered reconstructive health service

Note: A gap exception may be granted if there is not an in-network provider able to provide the requested Reconstructive Procedure. Check the federal, state or contractual requirements for benefit coverage.

Coverage Limitations and Exclusions

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

- Breast reconstruction has been successfully completed post Mastectomy and the member chooses to enlarge their breasts for cosmetic reasons.
- Breast reconstruction or scar revision after breast biopsy or removal of a cyst with or without a biopsy.
- Insertion of breast implants or reinsertion of breast implants for the purpose of improving appearance unless covered under a state or federal mandate.
- Liposuction other than to achieve breast symmetry during 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.
- Removal or replacement of an implant that is not ruptured and unassociated with local breast complications.
- 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.
- Revision of a prior reconstructed breast due to normal aging.

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.

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

Deep Inferior Epigastric Perforator (DIEP) Flap: DIEP stands for the deep inferior epigastric perforator artery, which runs through the abdomen. In a DIEP flap reconstruction, fat, skin, and blood vessels are cut from the wall of the lower belly and moved up to the chest to rebuild the breast. The surgeon reattaches the blood vessels of the flap to blood vessels in the chest using microsurgery. DIEP is often referred to as a muscle-sparing or muscle-preserving type of flap, which means that no muscle is taken from the abdomen.

Gluteal Artery Perforator (GAP) Free Flap:

- An SGAP flap (superior gluteal artery perforator), or gluteal perforator hip flap, uses this blood vessel to transfer a section of skin and fat from the upper buttocks/hip to reconstruct the breast.
- The IGAP flap (inferior gluteal artery perforator) uses this blood vessel to transfer a section of skin and fat from the bottom of the buttocks, near the buttock crease to reconstruct the breast.

Latissimus Dorsi (LD) Flap: The LD flap moves muscle (and skin if required) from the back to reconstruct the breast. It may be transferred as a free tissue transfer or rotated into place as a pedicle flap to reconstruct the breast. In a latissimus dorsi flap procedure, an oval flap of skin, fat, muscle, and blood vessels from the upper back is used to reconstruct the breast. This flap is tunneled to the chest to rebuild the breast.

Mastectomy: Mastectomy is the removal of the whole breast. There are five different types of Mastectomy: "simple" or "total" Mastectomy, modified radical Mastectomy, radical Mastectomy, partial Mastectomy, and subcutaneous (nipple-sparing) Mastectomy.

- Simple or Total Mastectomy: Removes the entire breast and no axillary lymph node dissection
- Modified radical Mastectomy: Modified radical Mastectomy involves the removal of both breast tissue and axillary lymph nodes
- Radical Mastectomy: Removes the entire breast, axillary lymph nodes, and the chest wall muscles
- Partial Mastectomy (lumpectomy, tylectomy, quadrantectomy, and segmentectomy): Partial Mastectomy is the removal of the cancerous part of the breast tissue and some normal tissue around it. While lumpectomy is technically a form of partial Mastectomy, more tissue is removed in partial Mastectomy than in lumpectomy.
- Nipple-Sparing Mastectomy: During nipple-sparing Mastectomy, all of the breast tissue is removed; however, the nipple is not removed

Poland Syndrome: Poland syndrome is a congenital absence of the pectoralis major muscle, usually the sternal component, as well as breast and areolar hypoplasia. This condition can also be associated with absence of the latissimus dorsi and serratus anterior muscles, hand symbrachydactyly, and other extremity deformities.

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 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.

Transverse Rectus Abdominus Myocutaneous (TRAM) Flap: The surgeon takes muscle and overlying lower abdominal tissue and moves it to the chest area. TRAM flap may be done as either a pedicle flap or a free flap.

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
Mastectomy	
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (urban type operation)
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

CPT Code	Description
Breast Reconstruction Post Mastectomy and Poland Syndrome	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)
19316	Mastopexy
19325	Breast augmentation with implant
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
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)
19396	Preparation of moulage for custom breast implant
19499	Unlisted procedure, breast
Covered to Achieve Symmetry of the Contralateral Breast Post Mastectomy Only	
19318	Breast reduction

HCPCS Code	Description
L8600	Implantable breast prosthesis, silicone or equal
S2066	Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral

HCPCS Code	Description
S2067	Breast reconstruction of a single breast with stacked deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral
S2068	Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
S8950	Complex lymphedema therapy, each 15 minutes

Diagnosis Code	Description
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.119	Malignant neoplasm of central portion of unspecified female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast

Diagnosis Code	Description
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.619	Malignant neoplasm of axillary tail of unspecified female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
C79.81	Secondary malignant neoplasm of breast
D05.00	Lobular carcinoma in situ of unspecified breast
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.80	Other specified type of carcinoma in situ of unspecified breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D05.90	Unspecified type of carcinoma in situ of unspecified breast
D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast
D48.61	Neoplasm of uncertain behavior of right breast
D48.62	Neoplasm of uncertain behavior of left breast
I97.2	Postmastectomy lymphedema syndrome
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
Q79.8	Other congenital malformations of musculoskeletal system
T85.43XA	Leakage of breast prosthesis and implant, initial encounter
T85.43XD	Leakage of breast prosthesis and implant, subsequent encounter
T85.43XS	Leakage of breast prosthesis and implant, sequela

Diagnosis Code	Description
Z42.1	Encounter for breast reconstruction following mastectomy
Z45.811	Encounter for adjustment or removal of right breast implant
Z45.812	Encounter for adjustment or removal of left breast implant
Z45.819	Encounter for adjustment or removal of unspecified breast implant
Z85.3	Personal history of malignant neoplasm of breast
Z90.10	Acquired absence of unspecified breast and nipple
Z90.11	Acquired absence of right breast and nipple
Z90.12	Acquired absence of left breast and nipple
Z90.13	Acquired absence of bilateral breasts and nipples

References

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UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Guideline History/Revision Information

Date	Summary of Changes
05/01/2021	**Template Update** • Replaced reference to "MCG™ Care Guidelines" with "InterQual® criteria" in *Instructions for Use*

02/01/2021	**Template Update**
	• Reformatted policy; transferred content to new template
	Title Change
	• Previously titled *Breast Reconstruction Post Mastectomy (for Tennessee Only)*
	Coverage Rationale
	• Removed language pertaining to the Women's Health and Cancer Rights Act of 1998
	• Added language to indicate treatment of Poland Syndrome with breast reconstruction is eligible for coverage as reconstructive and medically necessary; this is considered reconstructive surgery although no Functional Impairment may exist
	• Revised list of procedures that may be utilized during breast reconstruction; added:
	  ○ Mastopexy or breast reduction when required prior to mastectomy to preserve the viability of the nipple
	  ○ Autologous fat transplant (including the harvesting of fat and the injection)
	Definitions
	• Added definition of "Poland Syndrome"
	• Removed definition of "Women's Health and Cancer Rights Act of 1998, § 713 (a)"
	Applicable Codes
	• Updated list of applicable CPT codes to reflect annual edits:

Date	Summary of Changes
	Breast Reconstruction Post Mastectomy and Poland Syndrome ○ Removed 19324 and 19366 ○ Revised description for 11970, 11971, 19325, 19330, 19340, 19342, 19357, 19361, 19364, 19367, 19368, 19369, and 19380 *Covered to Achieve Symmetry of the Contralateral Breast Post Mastectomy Only* ○ Revised description for 19318 • Added ICD-10 diagnosis code Q79.8 Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version CS011TN.N

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.