BREAST RECONSTRUCTION POST MASTECTOMY

Policy Number: SURGERY 095.16 T2 **Effective Date**: December 1, 2018

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INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care 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.

CONDITIONS OF COVERAGE

Applicable Lines of Business/Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General benefits package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes[1,2]
Precertification with Medical Director Review Required	Yes[1]
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Inpatient, Office, Outpatient

Special Considerations	[1]Medical Director review is not required for reconstructive procedures following a Mastectomy for breast cancer (or prophylaxis). [2]**Participating Providers in the Office Setting**: Precertification is required for services performed in the office of a participating provider. **Non-Participating/ Out-of-Network Providers in the Office Setting**: Precertification is not required, but is encouraged for out-of-network services performed in the office. If precertification is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

Breast reconstruction is covered for members who have a Mastectomy with or without a diagnosis of cancer. Mastectomy includes partial (lumpectomy, tylectomy, quadrantectomy, and segmentectomy), simple, and radical. This benefit does not include aspirations, biopsy (open or core), excision of cysts, fibroadenomas or other benign or malignant tumors, aberrant breast tissue, duct lesions, nipple or areolar lesions, or treatment of gynecomastia.

The Women's Health and Cancer Rights Act of 1998 does not provide a timeframe by which the member is required to have the reconstruction performed post Mastectomy.

In accordance with Federal and State mandates, the following services are covered:

- 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

Breast Reconstruction:

The following procedures may be utilized during breast reconstruction:

A. 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

B. 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.

C. 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.

D. After the breast implant is completed, creation of a nipple (by various techniques) and areola (tattooing) may be performed.

If the original implant or reconstructive surgery was considered reconstructive surgery under the terems of the Oxford beneift document, coverage may exist for removal, replacement and/or reconstruction. If the original implant or reconstructive surgery was considered reconstructive surgery under the terms of the Oxford benefit document, then removal of a ruptured prosthesis is treating a "complication arising from a medical or surgical intervention." Removal or replacement of an implant that is not ruptured and unassociated with local breast complications may not be covered.

Revision of a reconstructed breast (CPT code 19380) may be considered reconstructive when the original reconstruction was performed following Mastectomy or for another covered health care service (see Applicable Codes section below for a list of codes that meet the criteria for a reconstructed breast).

Additional Information

An in-network exception may be granted if there is not an in-network provider able to provide the requested Reconstructive Procedure. Refer to the member specific benefit plan document and the In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy policy for information regarding coverage from out-of-network providers.

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
  - Compression Lymphedema sleeves are covered
  - 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.

Coverage Limitations and Exclusions

Please refer to the member specific benefit plan document and any federal or state mandates, if applicable.

- Insertion of breast implants or reinsertion of breast implants for the purpose of improving appearance is a cosmetic procedure unless covered under a state or federal mandate.
  - If the breast reconstruction has been successfully completed post Mastectomy and the member chooses to enlarge their breasts for cosmetic reasons, this is considered a cosmetic service and is not covered.
- Breast reconstruction or scar revision after breast biopsy or removal of a cyst with or without a biopsy usually does not meet the definition of a covered reconstructive health service. Refer to member specific benefit plan document and state mandates.
- Tissue protruding at the end of a scar ("dog ear"/standing cone), painful scars or donor site scar revisions must be reviewed to determine if the procedure meets reconstructive guidelines.
- Liposuction other than to achieve breast symmetry during post Mastectomy reconstruction is considered cosmetic and is not covered.
- Revision of prior reconstructed breast due to normal aging does not meet the definition of a covered reconstructive health service.
- Not medically necessary services.

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

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 Flap (LD): 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 - 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 .

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.

Women's Health and Cancer Rights Act of 1998, § 713 (a): "In general - a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a Mastectomy shall provide, in case of a participant or beneficiary who is receiving benefits in connection with a Mastectomy and who elects breast reconstruction in connection with such Mastectomy, coverage for (1) reconstruction of the breast on which the Mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications all stages of Mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient."

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 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 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
19304	Mastectomy, subcutaneous
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
Breast Reconstruction Post Mastectomy	
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

CPT Code	Description
Breast Reconstruction Post Mastectomy	
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 prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
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
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
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
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
19499	Unlisted procedure, breast
Covered to Achieve Symmetry of the Contralateral Breast Post Mastectomy Only	
19318	Reduction mammoplasty

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
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

HCPCS Code	Description
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

ICD-10 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
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

ICD-10 Diagnosis Code	Description
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
I97.2	Post mastectomy lymphedema syndrome
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
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

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee. [*CDG.003.10*]

American Society of Plastic Surgeons. Breast Reconstruction Procedures Steps. Available at: http://www.plasticsurgery.org. Accessed August 21, 2018.

Breastcancer.org. Accessed September 21, 2018.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
12/01/2018	• Updated list of related policies; added reference link to the policy titled *Skin and Soft Tissue Substitutes* • Updated conditions of coverage/special considerations; modified notation to clarify: ○ For **participating providers in the office setting**: Precertification is required for services performed in the office of a participating provider ○ For **non-participating/out-of-network providers in the office setting**: Precertification is not required, but is encouraged for out-of-network services performed in the office; if precertification is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered • Updated coverage rationale: ○ Restructured language pertaining to the Women's Health and Cancer Rights Act of 1998 to clarify this law does not provide a timeframe by which the member is required to have the reconstruction performed post Mastectomy ○ Modified language pertaining to surgical techniques; incorporated content previously outlined in the *Definitions* section of the policy to clarify the following procedures may be utilized during breast reconstruction: A. 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 B. 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 ▪ 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 C. 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 D. After the breast implant is completed, creation of a nipple (by various techniques) and areola (tattooing) may be performed ○ Modified language pertaining to revision of a reconstructed breast (CPT code 19380) to clarify this service may be considered reconstructive when the original reconstruction was *performed following* Mastectomy or *for another* covered health service • Removed definition of: ○ Breast Reconstruction Steps (relocated to *Coverage Rationale* section of the policy) ○ "Stacked" DIEP Flap ○ Superficial Inferior Epigastric Artery (SIEA) Flap • Updated list of applicable CPT codes; revised description for 15777 • Archived previous policy version SURGERY 095.15 T2