

BREAST REPAIR/RECONSTRUCTION NOT FOLLOWING MASTECTOMY

Policy Number: SURGERY 094.13 T2

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Related Policies

- [Breast Reconstruction Post Mastectomy](#)
- [Breast Reduction Surgery](#)
- [Cosmetic and Reconstructive Procedures](#)
- [Gender Dysphoria Treatment](#)
- [In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy](#)

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
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, Outpatient
Special Considerations	¹ Precertification with review by a Medical Director or their designee is required.

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

If the member's condition meets the Women's Health and Cancer Rights (WHCRA) criteria, please refer to the policy titled [Breast Reconstruction Post Mastectomy](#).

Criteria for a Coverage Determination as Reconstructive and Medically Necessary:

Removal of breast implants with capsulectomy/capsulotomy for symptomatic capsular contracture is considered reconstructive and medically necessary 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.

Removal of a deflated saline breast implant shell is considered cosmetic and is not medically necessary unless the implants were done post-mastectomy. Refer to the policy titled [Breast Reconstruction Post Mastectomy](#).

Correction of inverted nipples is considered reconstructive and medically necessary when one of the following criteria are met:

- Member meets the Women's Health and Cancer Rights Act (WHCRA) criteria (refer to the policy titled [Breast Reconstruction Post Mastectomy](#) for details); **or**
- Documented history of chronic nipple discharge, bleeding, scabbing or ductal infection.

Note: Correction of congenital inverted nipples may be covered based on the state mandates or member specific benefit plan document. See definition of [Congenital Anomaly](#) below.

Breast reconstruction performed to treat Poland Syndrome (see definition below) is reconstructive.

Although no Functional Impairment may exist for the breast reconstruction for Poland Syndrome, this has been deemed reconstructive surgery.

Removal of a ruptured silicone gel breast implant is covered regardless of the indication for the initial implant placement. 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.

Additional Information

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.

Coverage Limitations and Exclusions

Some states require coverage for services that Oxford considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to member specific benefit plan document.

- Cosmetic breast procedures are excluded from coverage. Examples include but are not limited to:

- 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 policy titled [Breast Reconstruction Post Mastectomy](#).)
- Breast reduction surgery that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic Functional Impairment or is related to coverage required by the Women's Health and Cancer Right's Act.
- Breast surgery only for the purpose of creating symmetrical breasts except when post mastectomy.
- Breast prosthetics or replacement following a cosmetic breast augmentation.
- Revision of a prior reconstructed breast due to normal aging does not meet the definition of a covered reconstructive health service.

DEFINITIONS

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

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.

Functional or Physical Impairment: A Physical or Functional 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.

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.

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 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
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19355	Correction of inverted nipples
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast

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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.005.08]

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 29, 2018.

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

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	<ul style="list-style-type: none">Updated coverage rationale; removed duplicative language pertaining to the diagnosis of anaplastic lymphoma (no change to guidelines)Archived previous policy version SURGERY 094.12 T2