

Breast Repair/Reconstruction Not Following Mastectomy

Policy Number: SURGERY 094.19 T2
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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](#)
- [Gynecomastia Treatment](#)
- [In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy](#)

Coverage Rationale

 See [Benefit Considerations](#)

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:
 - Member meets the [Women's Health and Cancer Rights Act \(WHCRA\)](#) criteria (refer to the Clinical Policy titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#) for details); or
 - 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 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.
- Removal of a deflated saline breast implant shell when the implants were done post mastectomy (refer to the Clinical Policy titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#) for details).
- Removal of a ruptured silicone gel breast implant regardless of the indication for the initial implant placement.

Note: Please refer to the Clinical Policy 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 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

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, or
- Treatment of gynecomastia

Coverage Limitations and Exclusions

Oxford 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 (unless it 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.
- 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 Clinical Policy titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#) for details)
- 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.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information
Breast Repair/Reconstruction Not Following Mastectomy
<p>Medical notes documenting the following, when applicable:</p> <ul style="list-style-type: none"> • History of the medical condition(s) requiring treatment or surgical intervention • Chief complaint, including history of the complaint and physical exam • Relevant medical-surgical history including dates • Upon request, we may require the specific diagnostic image(s) that show the abnormality for which surgery is being requested <ul style="list-style-type: none"> ○ Note: Diagnostic images must be labeled with the: <ul style="list-style-type: none"> ▪ Date taken and ▪ Applicable case number obtained at time of notification, or member's name and ID number on the image(s) ○ Submission of diagnostic image(s) is required via the external portal at www.uhcprovider.com/paan; faxes will not be accepted

Required Clinical Information

Breast Repair/Reconstruction Not Following Mastectomy

- Diagnostic image(s) report(s)
 - CPT codes 19370 and 19371 require submission of high-quality photograph(s)
 - Note: All photographs must be labeled with the:
 - Date taken and
 - Applicable case number obtained at time of notification, or member's name and ID number on the photograph(s)
 - Submission of color photographs can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photos will not be accepted
 - Complications which necessitate the need for removal of the prosthetic
- Note: For capsular contracture include Baker grade and functional impairment

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.

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

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.

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 an individual 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.

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."

Prior Authorization Requirements

Prior authorization is required in all sites of service.

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 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)

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Benefit Considerations

If the member's condition meets the Women's Health and Cancer Rights (WHCRA) criteria, refer to the Clinical Policy titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#) for details.

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.005.13]

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.

Women's Health and Cancer Rights Act of 1998. Available at: https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/whcra_factsheet.html. Accessed August 25, 2021.

Policy History/Revision Information

Date	Summary of Changes
12/01/2021	<p>Related Policies</p> <ul style="list-style-type: none">Added reference link to the Clinical Policy titled <i>Gynecomastia Treatment</i> <p>Documentation Requirements</p> <ul style="list-style-type: none">Updated list of <i>Required Clinical Information</i> <p>Supporting Information</p> <ul style="list-style-type: none">Archived previous policy version SURGERY 094.18 T2

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right 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. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies 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.