I. Policy: Breast Reconstruction Surgery Following Mastectomy or Lumpectomy

II. Purpose/Objective:
To provide a policy of coverage regarding Breast Reconstruction Surgery Following Mastectomy or Lumpectomy

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Reconstructive breast surgery in men or women may be performed in connection with a mastectomy, lumpectomy, or breast trauma causing disfigurement to re-establish symmetry between the two breasts. The procedure includes reconstruction of the mastectomy site, creation of a new breast and creation of a new nipple/areolar complex. This may also include surgery and reconstruction of the unaffected breast to produce a symmetrical appearance. Breast reconstructive surgery following mastectomy may be performed at the time of the mastectomy or any time post-operatively.

DEFINED BENEFIT: Coverage for post trauma and/or post-mastectomy breast reconstruction surgery is in accordance with any and all state and/or Federal mandates, including The Women’s Health and Cancer Rights Act, which currently includes:

- Reconstructive breast surgery, in all stages, on the diseased breast as a result of mastectomy, or lumpectomy resulting in significant deformity. Covered procedures include mastopexy, insertion of breast prostheses, the use of tissue expanders, or reconstruction with a latissimus dorsi myocutaneous flap, transverse rectus abdominis myocutaneous (TRAM) flap, superficial inferior epigastric perforator (SIEP) flap, superficial inferior epigastric artery (SIEA) flap, deep inferior epigastric perforator ( DIEP) flap, or similar procedure, , Ruben’s flap, superior or inferior gluteal artery free flap, transverse upper gracilis (TUG) flap, , superior gluteal artery perforator (SGAP) flap, profundal artery perforator flap, or similar procedures, including skin sparing techniques, associated nipple and areolar reconstruction and tattooing of the nipple area.

- Acellular dermal matrix products (such as but not limited to AlloDerm, DermaMatrix, FlexHD, AlloMax, DermACELL Strattice and SeriSurgical Scaffold) are covered for post mastectomy breast reconstruction.

- Surgery on the non-diseased breast (reduction or augmentation) to establish symmetry between the two breasts.

- Prosthesis (either implanted or external) and treatment of physical complications at all stages of the mastectomy including lymphedema
  - Removal and replacement of a ruptured breast implant (either silicone or saline) is reconstructive for implants inserted following mastectomy.

- Lymphedema treatments considered medically necessary include:
  - Complex Decongestive Physiotherapy
  - Lymphedema pumps
  - Compression lymphedema sleeves (not applicable to Medicare beneficiaries)

- Reconstructive breast surgery in members with congenital absence or significant deformity secondary to Poland syndrome

Benefits for post mastectomy reconstruction following a prophylactic mastectomy in the absence of active disease, but which is considered medically necessary based on projected risk assessment (e.g. BRCA testing, etc.) will be eligible to the extent described in this policy.

LIMITATIONS:
Areola and/or nipple tattooing is covered when provided by a licensed medical provider, operating within their scope of practice.

Nipple tattooing may be repeated once, after the initial procedure.

EXCLUSIONS:
Breast reconstruction for cosmetic reasons unrelated to trauma or mastectomy/lumpectomy is NOT COVERED.
Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH RECONSTRUCTIVE BREAST SURGERY:
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws.
regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

11920  Tattooing, intradermal introduction of opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq. cm or less
11921  ; 6.1 to 20 sq cm
11922  ; each additional 20 sq cm
11970  Replacement of tissue expander with permanent prosthesis
11971  Removal of tissue expander without insertion of prosthesis
15877  Suction assisted lipectomy; trunk (when specified as a breast reconstruction procedure following breast surgery)
19301  MASTECTOMY, PARTIAL (EG, LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY)
19302  MASTECTOMY, PARTIAL (EG, 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
19316  Mastopexy
19318  Reduction mammoplasty
19324  Mammaplasty, augmentation; without prosthetic implant
19325  Mammaplasty, augmentation; with prosthetic implant
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, with or 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
L8015  External breast prosthesis garment, with mastectomy form, post mastectomy
L8030  Breast prosthesis, silicone or equal
L8035  Custom breast prosthesis, post mastectomy, molded to patient model
L8039  Breast prosthesis, not otherwise specified
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
S2068  Breast reconstruction w/dep inferior epigastric perforator (DIEP) flap, including microvascular anastomosis and closure of donor site, unilateral.
15876  Lipectomy
C1789  Prosthesis, breast (implantable)
LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

The General Assembly of Pennsylvania, Senate Bill 1417.


Women’s Health and Cancer Rights Act of 1998


This policy will be revised as necessary and reviewed no less than annually

Devised: 2/03

Revised: 03/04 (definition, coding) 3/05, 3/06, 3/07 (Women’s Act Revision); 3/08, 1/13, 1/16 (added Limitations section); 1/17 (clarify indications); 12/17 (add covered procedures)

Reviewed: 3/09, 3/10, 3/11, 3/12, 1/14, 1/15