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Reconstructive Breast Surgery

Notification Issue Date: 12/23/2008

This is only a notification of the policy that will be in effect on 01/28/2009. For the current version of this policy, click the following link: [11.08.15g, Reconstructive Breast Surgery](#).

Medical Policy Bulletin

Title: Reconstructive Breast Surgery

Policy#: 11.08.15h

Application of Medical Policy is determined by benefits and contracts. Benefits may vary based on product line, group or contract. Medical necessity determination applies only if the benefit exists and no contract exclusions are applicable. Individual member benefits must be verified.

In products where members are able to self-refer to providers for care and services, members are advised to use participating providers in order to receive the highest level of benefits.

This Medical Policy/Technology document describes the status of medical technology at the time the document was developed. Since that time, new technology may have emerged or new medical literature may have been published. If the Medical Reviewer is aware of any new information on the subject of this document, please provide it promptly to the Medical Policy Department. This information can include medical literature or pertinent facts of an individual case in which extraordinary circumstances may exist. This type of information is relevant not only in considering whether current medical policy should be updated but also in applying current medical policy to requests for coverage.

Intent of Policy:

The intent of this policy is to communicate the medical necessity criteria for reconstructive breast surgery, including mastopexy and augmentation.

For information on policies related to this topic, refer to the Cross References Table in this policy.

Description:

Reconstructive breast surgeries are designed to restore the normal appearance of the breast. These surgical procedures can include augmentation with the

insertion of an implant, mastopexy (the lifting, reshaping, and fixation of sagging breast tissue), reduction mammoplasty, and/or nipple tattooing. The most common type of reconstructive surgery involves inserting a breast implant (augmentation) usually for the purpose of increasing the size of a breast.

Breast reconstruction may also use autologous tissue such as a free flap, a latissimus dorsi flap, or, more commonly, a transverse rectus abdominis myocutaneous (TRAM) flap. Flap surgery involves using an individual's own natural tissue for their breast reconstruction and is dependent on the adequacy of the adjacent blood supply at the transplant site.

Reconstructive breast procedures use a variety of materials and surgical methods. Several acellular matrices and/or surgical mesh products used to promote regenerative skin healing have received approval from the US Food and Drug Administration (FDA).

Reconstructive surgery may also be needed following explantation of a breast implant previously implanted for medical reasons. Mastopexy after explantation may be performed to raise, reshape, and restore the appearance of the breast.

Reduction mammoplasty is a reconstructive surgical procedure to reduce the size and weight of a breast. This procedure involves removing a portion of the breast, including the skin and underlying glandular tissue. The breast is reshaped, and the areola and nipple are repositioned. This surgery may be performed to restore symmetrical breast appearance. Reduction mammoplasty leaves surface scarring and may result in decreased sensation in the nipple and breast.

Breast reconstruction may also involve the creation of a nipple and areola. Nipple and/or areola tattooing may be performed for repigmentation purposes. Hypopigmented areas of the dermis of the reconstructed nipple and areola are tattooed with nonreactive, hypoallergenic natural iron oxide-colored pigments.

Following mastectomy, or lumpectomy for a malignancy, breast reconstructive procedures are performed to achieve symmetry of the ipsilateral breast. In some cases, they are performed to the contralateral normal breast to achieve bilateral symmetry.

Congenital deformities such as Poland's syndrome, trauma, and chest injuries may be causative factors for reconstructive breast surgery. Poland's syndrome is a rare congenital defect that involves the underdevelopment or absence of chest musculature on one side of the rib cage, and may be evidenced by the absence or underdevelopment of the affected side's breast.

Because the purpose of reconstructive breast surgery is to restore the normal appearance of the breast, some procedures may need to be performed on the contralateral normal breast in order to achieve symmetry.

Policy:

When performed as a cosmetic service, reconstructive breast surgery is a benefit contract exclusion. However, reconstructive breast surgery (mammoplasty),

which may include augmentation, autologous tissue (eg, transverse rectus abdominis myocutaneous [TRAM flap]), mastopexy (breast lift), reduction mammoplasty, and nipple tattooing, is considered medically necessary and, therefore, covered for any of the following medical indications:

- Following mastectomy, which includes surgery to achieve symmetry of the contralateral breast
- Following any medically necessary breast surgery procedure when the defect in the operative breast produces enough volume loss to cause visible asymmetry (eg, lumpectomy)
- Postexplantation of an implant originally inserted during medically necessary reconstruction surgery
- Congenital anomalies (eg, Poland's syndrome, breast hypoplasia or absence)
 - Reduction of the contralateral breast for congenital anomalies
 - Please note: Normal mammary development allows for a degree of relative asymmetry in which one breast is commonly larger than the other. A very small breast or a breast that fails to develop should be distinguished from a certain normal degree of asymmetry in which one breast is commonly larger than the other.
- Traumatic chest injuries such as, but not limited to, burns or radiation necrosis

The Women's Health and Cancer Rights Act of 1998* and individual state mastectomy coverage laws require coverage for prostheses and reconstructive breast surgery incidental to the mastectomy as follows:

- State-mandated benefits allow coverage for any revisions of previous reconstructive breast surgery performed for medically necessary indications.
- Following mastectomy, there is no restrictive time limit for coverage of reconstructive breast surgery or coverage of prosthetic devices that may be inserted during reconstructive surgery. Additional requests for revision and reconstruction (not related to a complication) require cosmetic review.
- All treatment of physical complications resulting from mastectomy (including lymphedema) must be covered.
- Upon cosmetic review, initial requests for reconstructive breast surgery following open excisional procedures are eligible for reimbursement.
 - Subsequent requests for treatment of complications are considered medically necessary.
 - Requests for reconstructive breast surgery following nonopen (eg, percutaneous) and/or nonexcisional (eg, ductal exploration) procedures on the breast are reviewed on the basis of being potentially cosmetic procedures.

** The Women's Health and Cancer Rights Act does not apply to members enrolled in Medicare Advantage products.*

When used in reconstructive breast surgery, the application and placement of human acellular dermal allograft using material approved by the US Food and Drug Administration (FDA) is medically necessary and considered for separate reimbursement for individuals who meet the medical necessity criteria for reconstructive breast surgery.

MEDICARE

Breast reconstruction of the affected and contralateral unaffected breast following a medically necessary mastectomy is considered reconstructive and medically necessary and, therefore, covered.

All stages of reconstruction of the diseased breast, procedures to restore and achieve symmetry on the opposite breast (including augmentation, reduction, or mastopexy), prostheses, and the treatment of any complications of mastectomy are considered medically necessary and, therefore, covered.

Nipple tattooing to recreate the nipple and/or areola is considered medically necessary and, therefore, covered when performed as part of a breast reconstructive surgery that is covered.

REQUIRED DOCUMENTATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to, records from the physician's office, hospital, nursing home, home health agency, other health care professionals, therapies, and test reports.

The Company may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be made available to the Company upon request.

All requests for reconstructive breast surgery require review by the Company and must include documentation. This documentation is to include, but is not limited to, color photographs, letter of medical necessity from provider, documentation from the individual's medical records, and other health care professional reports.

Guidelines:

BENEFIT APPLICATION

Subject to the terms and conditions of the applicable benefit contract, reconstructive breast surgery is covered under the medical benefits of the Company's products when medical necessity criteria in the medical policy are met.

MEDICARE

This policy is consistent with Medicare's coverage criteria. The Company's payment methodology may differ from Medicare.

MANDATES

This policy is consistent with applicable state and federal mandates.

References:

Notification

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CODING TABLE

Code System	Code Number(s) and Narrative(s)
CPT	11920, 11921, 11922, 11970, 11971, 19316, 19318, 19324, 19325, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19380, 19396 THE FOLLOWING CODES ARE USED TO REPORT THE APPLICATION AND PLACEMENT OF HUMAN ACELLULAR DERMAL ALLOGRAFT: 15330, 15331
ICD Procedure	N/A
ICD Diagnosis	173.5: Other malignant neoplasm of skin of trunk, except scrotum 174.0: Malignant neoplasm of nipple and areola of female breast 174.1: Malignant neoplasm of central portion of female breast 174.2: Malignant neoplasm of upper-inner quadrant of female breast 174.3: Malignant neoplasm of lower-inner quadrant of female breast 174.4: Malignant neoplasm of upper-outer quadrant of female breast 174.5: Malignant neoplasm of lower-outer quadrant of

female breast

174.6: Malignant neoplasm of axillary tail of female breast

174.8: Malignant neoplasm of other specified sites of female breast

174.9: Malignant neoplasm of breast (female), unspecified site

175.0: Malignant neoplasm of nipple and areola of male breast

175.9: Malignant neoplasm of other and unspecified sites of male breast

198.2: Secondary malignant neoplasm of skin

198.81: Secondary malignant neoplasm of breast

233.0: Carcinoma in situ of breast

610.1: Diffuse cystic mastopathy

610.2: Fibroadenosis of breast

610.3: Fibrosclerosis of breast

611.1: Hypertrophy of breast

611.71: Mastodynia

611.72: Lump or mass in breast

611.79: Other sign and symptom in breast

611.81: Ptosis of breast

611.82: Hypoplasia of breast

611.83: Capsular contracture of breast implant

611.89: Other specified disorders of breast

612.0: Deformity of reconstructed breast

612.1: Disproportion of reconstructed breast

756.3: Other congenital anomaly of ribs and sternum

756.81: Congenital absence of muscle and tendon

757.6: Specified congenital anomalies of breast

793.80: Unspecified abnormal mammogram

793.81: Mammographic microcalcification

793.89: Other abnormal findings on radiological examination of breast

909.2: Late effect of radiation

909.3: Late effect of complications of surgical and medical care

942.01: Burn of trunk, unspecified degree of breast

942.31: Full-thickness skin loss due to burn (third degree NOS) of breast

942.41: Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of a body part

942.51: Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of a body part

959.11: Other injury of chest wall

990: Effects of radiation, unspecified

996.54: Mechanical complication due to breast prosthesis

996.69: Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft

996.79: Other complications due to other internal prosthetic device, implant and graft

998.59: Other postoperative infection

V10.3: Personal history of malignant neoplasm of breast

V10.43: Personal history of malignant neoplasm of ovary

V16.3: Family history of malignant neoplasm of breast

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V16.41: Family history of malignant neoplasm, ovary

V16.8: Family history of other specified malignant neoplasm

V45.71: Acquired absence of breast and nipple

V45.83: Breast implant removal status

V51.0: Encounter for breast reconstruction following mastectomy

V50.41: Prophylactic breast removal

V52.4: Fitting and adjustment of breast prosthesis and implant

V84.01: Genetic susceptibility to malignant neoplasm of breast

V84.02: Genetic susceptibility to malignant neoplasm of ovary

HCPCS Level II

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

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

Revenue Codes

N/A

Policy Effective Date: 01/28/2009

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