MEDICAL COVERAGE POLICY	
SERVICE: Breast Reconstruction Surgery and Prophylactic Mastectomy	
Policy Number:	140
Effective Date:	12/01/2020
Last Review:	10/29/2020
Next Review Date:	10/29/2021

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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(For breast reduction see Medical Coverage Policy 209)

PRIOR AUTHORIZATION: Required for non-cancer-related diagnoses.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). If there is no applicable NCD or LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

SWHP/FirstCare covers medically necessary mastectomy (including prophylactic mastectomy), and breast reconstruction, and uses criteria based on reasonable medical evidence to facilitate fair, impartial, and consistent coverage decisions.

Prophylactic mastectomy, including total (simple) mastectomy or subcutaneous mastectomy, may be considered medically necessary to prevent or reduce the risk of breast cancer in the following situations:

- In a female patient with a known BRCA1 or BRCA2 mutation confirmed by genetic testing;
- In a male or female patient with a personal history of breast cancer;
- In a female patient with a personal history of ovarian cancer;
- In women with a strong family history of breast cancer as indicated by the occurrence of breast cancer in a first-degree relative, especially a premenopausal mother or sister; early-age at cancer diagnosis in a first- or second-degree relative; multiple first- and/or second-degree relatives with breast cancer.
- In women with severe fibrocystic disease who have had multiple biopsies and who are regularly being re-evaluated for possible breast cancer.

Breast Reconstruction:

In accordance with the Women's Health & Cancer Rights Act of 1998, breast reconstruction following medically necessary mastectomy is covered, including nipple areolar complex

tattooing, as are procedures of the contralateral breast to achieve symmetry. In addition, prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema are covered.

Reconstructive surgery (including breast reduction, augmentation, and/or mastopexy) is considered medically necessary in situations where there is medical record documentation supporting presence of:

1. Congenital chest wall deformity such as Poland Syndrome that results in respiratory compromise or exercise intolerance.
   OR
2. Severe disfigurement resulting from trauma (accidental injury) or disease.

Breast reconstruction is **NOT** medical necessary after removal of breast implants (even when removal of breast implant met medical necessity criteria). This is considered cosmetic and not covered unless the original implants were inserted following a medically necessary mastectomy or after repair of a congenital chest wall deformity associated with respiratory compromise or exercise intolerance.

Post-Mastectomy reconstruction to repair or restore appearance of one or both breasts **IS** covered for male or female members. Under state and federal mandates, post-mastectomy reconstruction includes:

1. Reconstruction of the affected breast and nipple, including nipple areolar complex tattooing, in a manner determined in consultation between the member and attending physician;
2. Surgical reconstruction of the unaffected breast including mastopexy, reduction or augmentation of the non-diseased breast to produce a symmetrical appearance; and/or
3. Reconstructive surgery required for physical complications of all stages of mastectomy (e.g., lymphedema)

Breast reconstruction for all other reasons is considered cosmetic and is not medically necessary.

MANDATES: Under Women's Health and Cancer Rights Act (WHCRA) of 1998, group health plans, insurance companies and health maintenance organizations offering mastectomy coverage also must provide coverage for certain services relating to the mastectomy in a manner determined in consultation with the member and his/her attending physician, whether or not the mastectomy was covered by SWHP/FirstCare. Required coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Nothing in the law limits WHCRA rights to women or cancer patients.

CMS guidelines:

National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2)
Local Coverage Determination (LCD) L35090

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	19303 - Simple mastectomy 19304 - Subcutaneous mastectomy 19316 - Mastopexy, 19318 - Reduction mammaplasty, 19324 - Mammaplasty, augmentation, 19325 - Mammaplasty, augmentation with implant, 19328 - Removal of intact mammary implant, 19330 - Removal of mammary implant material, 19340 - Breast prosthesis following mastopexy, mastectomy or in reconstruction, 19342 - Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction, 19350 - Nipple/areola reconstruction, 19357, 19361, 19364,19366,19367,19368,19369 - Breast reconstruction, 19370 - Open periprosthetic capsulotomy, 19371 - Periprosthetic capsulectomy, 19380 - Revision of reconstructed breast, 19396 - Preparation of moulage for custom breast implant, 11920, 11921, 11922 - Tattooing to correct color defects 11970,11971 - Replacement of tissue expander with permanent prosthesis 21740, 21743 Reconstructive repair of pectus excavatum
HCPCS Codes:	L8020 Breast prosthesis, silicone or equal, L8039 Breast prosthesis, L8600 Implantable breast prosthesis, silicone or equal, S2066, S2067, S2068 Breast reconstruction. (These codes not payable by Medicare.)
ICD-10 Codes:	C50.011 - C50.929 – Malignant neoplasms of breast C79.81 – Secondary malignant neoplasm of breast D05.00 - D05.92 – Carcinoma in situ of breast N60.11 - N60.19 – Diffuse cystic mastopathy M95.4 – Acquired deformity of chest and ribs Q67.6 – Pectus excavatum Q76.6 – Other congenital malformations of ribs Q76.7 – Congenital malformation of sternum Z80.3 – Family history of malignant neoplasm of breast Z85.3 – Personal history of malignant neoplasm of breast Z90.10 – Acquired absence of unspecified breast and nipple

POLICY HISTORY:

Status	Date	Action
New	6/1/2010	New policy
Reviewed	12/2/2011	Reviewed.
Reviewed	8/2/2012	Reviewed
Reviewed	11/29/2012	Reviewed and revised.
Reviewed	11/14/2013	No changes.
Reviewed	11/6/2014	Added reference to policy 209; added CMS language
Reviewed	10/22/2015	Minor revisions
Reviewed	11/17/2016	No changes
Reviewed	10/24/2017	Minor revisions

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Reviewed	09/11/2018	Minor revisions
Reviewed	11/26/2019	No changes
Reformatted	10/29/2021	Reformatted for FirstCare use

REFERENCES: The following scientific references were utilized in the formulation of this medical policy. SWHP/FirstCare will continue to review clinical evidence surrounding aquatic therapy and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP/FirstCare so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

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17. Sadove, AM, Van Aalst JA. Congenital and Acquired Pediatric Breast Anomalies: A Review of 20 Years' Experience. Plastic & Reconstructive Surgery. 115(4):1039-1050, April 1, 2005