Breast Surgery Post Mastectomy

State(s): ☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	*LOB(s):* ☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Insurers offering health benefits plans are required to provide coverage, or reimbursement for mastectomy-related services including all stages of reconstruction of the breast on which a mastectomy a lumpectomy or a partial mastectomy was performed and on the other breast to produce a symmetrical appearance. Symmetrical appearance includes size, shape, color, and texture of both breasts, including visible scars located in or on the breast tissue of either breast when such scarring is a result of the treatment of breast cancer. Additionally, the requirement for payment, coverage, or reimbursement for reconstruction surgery when that surgery is associated with a mastectomy has no time limitation and is subject to the same terms and conditions that apply to other plan benefits.

Reconstructive breast surgery is defined as those surgical procedures that are performed to restore the appearance of the breast to a more normal state after surgery, accidental injury or trauma. Mastectomy is the most common indication for reconstructive breast surgery. Reconstructive breast surgery of an unaffected breast to achieve symmetry following mastectomy for disease, injury or trauma may also be considered medically necessary if the attending physician recommends this as part of the member's treatment plan. The types and timing of these procedures varies, depending on the individualized treatment plan devised by the treating physician and the individual. Timing may be impacted by the overall treatment plan for the breast cancer itself.

Note: *This policy does not address Gender Affirming services. Please refer to Gender Affirming Surgery and Related Procedures policy for any gender affirming related information.*

Criteria

Reconstructive breast surgery requires a one-time preauthorization. Consistent with the Women's Health and Cancer Rights Act of 1998, PacificSource provides coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

Once an authorization is in place, all stages of reconstruction, prostheses, treatment of physical complications and hospitalizations are covered as defined above. No further authorization is required. Contract benefits apply to the available coverage.

Health services shall indicate on the preauthorization notice that the authorization includes all stages of reconstruction, prostheses, treatment of physical complications and hospitalizations related to post-mastectomy services (Preauthorization Explanation Code: A73). No further authorization is required.

Once the preauthorization for reconstruction is in place, claims for the following CPT codes are eligible for payment (at the contracted benefit) without further PA if they are part of the original staged surgery.

	Description
11920*	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.0 sq cm or less.
11921*	Tattooing, intradermal introduction of insoluble opaque pigments To Correct Color Defects of skin; 6.1-20.0 sq cm
11922*	Tattooing, intradermal introduction of insoluble opaque pigments To Correct Color Defects of skin: additional 20.0 sq cm
11970	Replacement tissue expander, permanent prosthesis
11971	Removal of tissue expanders w/o insertion of prosthesis
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19328	Removal of intact mammary implant

19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or 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 dorsal flap, 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
19370	Open periprosthetic capsulectomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
L8600	Implantable breast prosthesis, silicone or equal
S2066	Breast GAP flap reconstruction
S2067	Breast "stacked" DIEP/GAP
S2068	Breast reconstruction with deep flap

Cosmetic breast surgery is defined as surgery intended to reshape normal structures of the body to improve appearance and self-esteem. Breast augmentation and reduction mammoplasty may fall into this category. Review contract language: contract exclusions may apply.

Removal or replacement of breast implants may be considered a medically necessary covered procedure when an implant was placed for medically necessary reconstructive purposes, and when due to a contracture or rupture of the prosthesis according to contract criteria. Removal of silicone, or other implants placed for cosmetic reasons are not covered under some plans. New reconstruction is not covered under some plans.

Complications associated with implanted breast prostheses include capsular contracture, persistent infection, implant extrusion, tissue necrosis, and implant deflation or rupture. These conditions, when they become clinically significant, may require removal of the implant.

If an implant originally placed for reconstructive purposes as defined above, develops any of these complications or develops a visible distortion (Baker Class III contracture), removal of the implant and reimplantation is considered reconstructive. Contracture is the most common local complication of breast implants. Contractures have been graded according the Baker Classification which is outline below:

- Grade I Augmented breast feels as soft as a normal breast.
- Grade II Breast is less soft and the implant can be palpated but is not visible.
- Grade III Breast is firm, palpable, and the implant (or its distortion) is visible.
- Grade IV Breast is hard, painful, cold, tender, and distorted.

Removal, repair, and/or replacement of a prostheses is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

PacificSource does not require preauthorization for mastectomy, except mastectomy for males (CPT 19300-19307) including adolescent gynecomastia.

CPT/HCPC	Codes for Prosthesis (see DME matrix)
L8600	Implantable breast prosthesis, silicone or equal
L8000-L8002; L8010 L8015; L8020; L8030 L8035; L8039	Mastectomy bra and garments with and without prosthesis
	Codes for Lymphedema
S8950	Complex lymphedema therapy
E0650 –E0655 E0665; E0668; E0672	Pneuma-compression garments

Health Services will request documentation from the provider to verify the type of implant they plan to use.

Note: *Nipple tattooing may be done by non-participating providers who are also ineligible providers (e.g. tattoo parlors). These providers may bill using CPT code 11920, 11921, 11922 or the member*

may pay at the time of service and submit the claim for reimbursement. Nipple tattoo providers, or the member who purchased the service, may be reimbursed at the participating provider payment rate for office services/supply. All deductibles and coinsurance apply.

The claims adjudicator may contact Health Services if there are any questions as to whether the claims submitted are included under the reconstructive breast services preauthorization. Members who are new to PacificSource and have undergone mastectomy, or other mastectomy related services under another carrier, are subject to preauthorization for those services that fall under our preauthorization guidelines. However, once any authorization is in place, continued coverage is available for on-going care at contracted benefit rates, subject to other limitations in this policy and/or contracted benefits.

Medicaid

PacificSource Community Solutions follows Guideline Notes 43, 79, and 196 of the OHP Prioritized List of Health Services, and per Oregon Administrative Rules (OAR) 410-122-0658 for coverage of Post Mastectomy Related Services

Medicare

PacificSource Medicare follows National Coverage Determination (NCD) 140.2 for Breast Reconstruction Following Mastectomy.

Related Medical Policies

Gender Affirming Surgery and Related Procedures

Reduction Mammoplasty

References

Center for Devices and Radiological Health, U.S. Food and Drug Administration. FDA Update on the Safety of Silicone Gel-Filled Breast Implants. June 2011. http://www.fda.gov/downloads/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/BreastImplants/UCM260090.pdf

FDA Breast Implants. Silicone Gel-Filled Breast Implants. September 20, 2013. http://www.fda.gov/medicaldevices/productsandmedicalprocedures/implantsandprosthetics/breastimplants/ucm063871.htm

Women's Health and Cancer Rights Act of 1998. Accessed 10/23/2018, 10/14/2019, 07/30/2020 http://www.dol.gov/dol/topic/health-plans/womens.htm

Appendix

Effective: 9/1/2020 **Next review:** 9/1/2021

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): O.R.S. 743.A.110