UHA
HEALTH INSURANCE

Breast Reconstruction Surgery

I. Policy

University Health Alliance (UHA) will reimburse for Breast Reconstruction Surgery when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. UHA considers reconstructive breast surgery medically necessary after a medically necessary mastectomy or partial mastectomy that results in a significant deformity amenable to surgical correction.
   a. This benefit does not include aspirations, biopsy (open or core), excision of cysts, aberrant breast tissue, duct lesions, nipple or areolar lesions, or treatment of gynecomastia.
   b. There is not a time frame in which the enrollee is required to have the reconstruction done post mastectomy under the Women's Health and Cancer Rights Act of 1998.

B. Medically necessary procedures include (when applicable):
   a. The use of tissue expanders, insertion of breast prostheses, contralateral mastopexy, or autologous tissue reconstruction.
   b. Autologous fat grafting as a replacement for implants for breast reconstruction or to fill defects after breast conservation surgery or other reconstructive techniques, is covered only when appropriate.

C. UHA considers associated nipple and areola reconstruction and tattooing of the nipple area medically necessary.

D. In accordance with Federal mandates the following are covered:
   a. All stages of reconstruction of the breast on which the mastectomy was performed
   b. Surgery and reconstruction of the contralateral breast to produce a symmetrical appearance, including nipple tattooing
   c. Prostheses (implanted or external)
   d. Treatment of physical complications of mastectomy, including lymphedema and infection
      i. Complex Decongestive Physiotherapy (CDP) is covered for the confirmed complication of lymphedema post-mastectomy.
      ii. Lymphedema pumps when required are covered.
      iii. Compression lymphedema sleeves are covered.
      iv. Elastic bandages and wraps associated with covered treatments for the complications of lymphedema are covered.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is

not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. UHA considers breast reconstructive surgery to correct breast asymmetry cosmetic except for:

1. Surgical correction of chest wall deformity causing functional deficit in Poland syndrome; or
2. Repair of breast asymmetry due to a medically necessary mastectomy or a medically necessary partial mastectomy that results in a significant deformity; or
3. Prompt repair of breast asymmetry due to trauma.

B. In all cases, the following applies:

1. All breasts have some identifiable and measurable asymmetry. The goal of surgery is not perfect symmetry, but rather to produce the closest approximation of symmetry (i.e., generally one cup size difference in breast size or less). Extent of deformity caused by prior surgery, radiation, projection of chest wall, skin aging, and scar tissue may make surgical correction of symmetry unachievable.
2. The patient's expectations and the limitations of surgical reconstruction must be thoroughly disclosed by the surgeon and understood by the patient prior to reconstruction and documented as such in the informed signed consent for payment eligibility.
3. Smoking cessation must be addressed preoperatively.
4. UHA does not recognize deep inferior epigastric perforator (DIEP) as rendering a superior health outcome relative to transverse rectus abdominis myocutaneous flap (TRAM) reconstruction.
5. Removal of a breast implant with or without reimplantation is considered **reconstructive** when originally placed in an individual meeting the reconstruction criteria in A.1-3 above, for any of the following indications:
    a. Breast cancer in the implanted breast or remnant, or in the contralateral breast, where implant removal is necessary to excise the breast cancer.
    b. Breast implant-associated anaplastic large cell lymphoma; or
    c. Extrusion of implant through skin; or
    d. Implants complicated by recurrent infections; or
    e. Implants with Baker Class III or IV contracture associated with severe pain; or
    f. Implants with severe contracture that interferes with mammography; or
    g. Intra- or extra-capsular rupture of silicone gel-filled implants; or
    h. Members who exhibit cutaneous hypersensitivity-like reactions associated with breast implants and who have failed conventional treatments (e.g., antibiotics, oral corticosteroids, and topical corticosteroids); or
    i. Extra-capsular rupture of saline implant if the rupture compromises the cosmetic outcome of the implant.

6. Removal or replacement of an implant (any type) that is not ruptured and unassociated with local breast complications will not be covered.

C. Replacement of implants, which were used for cosmetic and not post-mastectomy reconstruction, and revision of cosmetic breast augmentation are non-covered.

D. UHA considers Biodesign Nipple Reconstruction Cylinder experimental and investigational because its effectiveness has not been established.

E. UHA covers all post-mastectomy breast reconstruction surgery in compliance with the Women's Health and Cancer Rights Act of 1998 (WHCRA). Including but not limited to:

1. Cancer does not have to be the reason for the mastectomy.
2. The mandate applies to men as well as women.
3. WHCRA mandates coverage for all stages of breast reconstruction. The final stage of reconstruction is defined as the achievement of reasonable symmetry and when appropriate and desired, nipple tattooing and reconstruction.
    a. Reconstruction is not considered "incomplete" if the patient becomes dissatisfied with cosmetic result of reconstruction or where future medical or surgical conditions may alter results.
    b. The patient's expectations and the limitations of surgical reconstruction must be thoroughly disclosed by the surgeon and understood by the patient prior to reconstruction and documented as such in the informed signed consent for payment eligibility.
4. WHCRA does not mandate coverage for revision of a completed breast reconstruction to improve appearance.
    a. UHA recognizes and is in agreement with **The American Society of Plastic Surgeons** in acknowledging that revision of cosmetic reconstructions may not be eligible for coverage and those patients who choose to have breast reconstruction need to understand the potential for future surgery to maintain the quality of their breast reconstruction(s) and their financial exposure to these cosmetic revisions.

IV. Administrative Guidelines

A. Prior authorization is not required except for all out-of-state procedures.

B. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and must be made available to UHA upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.

CPT codes covered if selection criteria are met:

CPT Code	Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
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 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, 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 capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant

CPT codes not covered if selection criteria are met:

CPT Code	Description
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Other CPT codes related to CPB:

CPT Code	Description
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure)
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

HCPCS codes covered if selection criteria are met:

HCPCS Code	Description
C1789	Prosthesis, breast (implantable)

L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8032	Nipple prosthesis, reusable, any type, each
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

V. Policy History

Policy Number: MPP-0101-130115

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References:

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."

Surgery of cosmetic sequelae after breast-conserving therapy. Regano S, Hernanz F, Arruabarrena A. Breast J. 2010 Jul-Aug; 16(4):389-93 Epub2010 Apr21

BCBS of Kansas Surgery Liaison Committee, CB, Sept 2012, BCBS Kansas payment policy