Breast Reconstructive Surgery

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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY PURPOSE AND STATEMENT

Highmark Health Options may provide coverage under the medical surgical benefits of the Company's Medicaid products for medically necessary breast reconstructive surgery.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently serves Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan and Health Plan Plus members.

Lumpectomy – Removal of the breast tumor and surrounding tissue.

Prophylactic Mastectomy – Removal of the breast in the absence of malignant disease.

Reconstructive Breast Surgery – Surgical procedures performed to correct or repair abnormal structures of the breast that are designed to restore the normal appearance of one breast or both breasts.

Reconstructive Surgery – Surgical procedures performed on abnormal structures of the body caused by congenital deformity, trauma, infection, tumors, or disease. These procedures are performed to improve function but may also be done to approximate a normal appearance.

Reduction Mammoplasty – A surgical procedure to decrease breast size.

TYPES OF BREAST RECONSTRUCTIVE SURGERY

Mastectomy

Mastectomy may be considered medically necessary for the symptoms and diagnosis, or treatment of the individual's condition, illness, or injury.

The type of mastectomy (subcutaneous, partial, modified, or radical) and the timing of the surgery vary for each individual and are determined by the surgeon.

Mastectomy for Fibrocystic Breasts

Fibrocystic breasts are considered a condition or a disorder with or without mild to severe symptoms. Mastectomy for fibrocystic breasts may be considered medically necessary:

- When the individual is symptomatic;* and
- Has been unresponsive to conservative treatment**; and/or
- A biopsy has been performed.

*Symptoms of fibrocystic breasts include, but are not limited to: breast engorgement attended by pain and tenderness, generalized lumpiness or isolated mass or cyst.

**Conservative treatment for fibrocystic breasts consists of, but is not limited to: support bras, avoiding trauma, avoiding caffeine, medication for pain, anti-inflammatory drugs, hormonal manipulation, use of vitamin E, use of diuretics, and salt restrictions.

Prophylactic Mastectomy

Prophylactic mastectomy is defined as the removal of the breast in the absence of malignant disease. Prophylactic mastectomies may be performed in women considered at high risk of developing breast cancer, either due to a family history, presence of a BRCA1, BRCA2, or PALB2 gene mutation, or the presence of lesions associated with an increased cancer risk.

Prophylactic mastectomy may be considered medically necessary when ONE or more of the following risk factors are present:

- Those with a strong family history of breast cancer such as:
  - Having a mother, sister, and/or daughter who was diagnosed with bilateral breast cancer or with breast cancer before age 50 years; or
  - A family history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (family cancer syndrome); or
- Individual has tested positive for BRCA1, BRCA2, or PALB2 gene mutations; or
- High-risk histology: Atypical ductal or lobular hyperplasia, or lobular carcinoma in situ confirmed on biopsy; or
- Strong family history, or no demonstrable gene mutations; or
- Individuals with such extensive mammographic abnormalities (i.e., calcifications), or dense breasts; or
- Individuals with a personal history of breast cancer making it more likely to develop a new cancer in the opposite breast; or
- Li-Fraumeni syndrome or Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome; or
- Individuals who received radiation therapy to the thoracic region before the age of 30. (e.g., radiation to treat Hodgkin's disease); or

- Individuals with lobular carcinoma in situ (LCIS) plus a family history of breast cancer.

Mastectomy of the contralateral breast may be considered medically necessary when ONE or more of the following situations exists:

- For risk reduction in individuals at high risk for a contralateral breast cancer as stated above; or
- For individuals in whom subsequent surveillance of the contralateral breast would be difficult such as for:
  - Dense breast tissue as shown clinically or mammographically; or
  - Diffuse and/or indeterminate calcifications; or
- For improved symmetry in individuals undergoing mastectomy with reconstruction for the index cancer who:
  - Have a large and/or ptotic contralateral breast; or
  - Disproportionately sized contralateral breast.

Coverage for reconstructive breast surgery is provided for individuals undergoing covered prophylactic mastectomies.

Prophylactic mastectomy for any other reason is considered not medically necessary.

Nipple Sparing Mastectomy (NSM)

Nipple sparing/skin sparing mastectomy may be considered medically necessary when there is no cancer involving the skin, nipple or areola.

Removal of Breast Implant

Removal of a silicone gel-filled breast implant may be considered medically necessary:

- In all cases for a documented implant rupture, infection, extrusion, Baker class IV contracture, in cases of surgical treatment of breast cancer.

Removal of a saline-filled breast implant may be considered medically necessary for EITHER of the following indications:

- In a documented implant rupture for those patients who had originally undergone breast implantation for reconstructive purposes; or
- In cases of infection, extrusion, Baker class IV contracture, or surgical treatment of breast cancer.

Removal of a breast implant associated with a Baker class III contracture may be considered medically necessary:

- In those patients who had originally undergone breast implantation for reconstructive purposes.

The following indications for removal of breast implants are considered not medically necessary:

- Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases, etc.; or
- Individual's anxiety; or
- Baker class III contractures in individuals with implants for cosmetic purposes; or
- Rupture of a saline implant in individuals with implants for cosmetic purposes; or

- Pain not related to contractures or rupture.

Reconstructive Surgery

Reconstructive breast surgery may be considered medically necessary for ANY of the following indications:

- After a medically necessary mastectomy; or
- Accidental injury; or
- Trauma.

Reconstructive breast surgery after removal of an implant may be considered medically necessary:

- Only in those patients who had originally undergone breast implantation for reconstructive purposes.

Reconstruction may be performed by an implant-based approach or through the use of autologous tissue.

Removal of implants requires documentation of the original indication for implantation and the type of implant, either saline- or silicone gel-filled, and the current symptoms, either local or systemic.

Surgery on the Contralateral Breast to Produce Symmetry

Surgery* on the contralateral breast to produce a symmetrical appearance after removal of an implant and re-implantation may be considered reconstructive and medically necessary:

- When the implant was originally placed for reconstructive purposes in an individual with a history of mastectomy, lumpectomy or treatment of breast cancer.

* Types of reconstructive surgical procedures on the diseased breast include, but are not limited to:

- Nipple/areola reconstruction.
- Nipple tattooing will be covered if the medical necessity criteria for reconstructive breast surgery is met.
  - Nipple tattooing is considered cosmetic for all other indications.
- Transverse rectus abdominis myocutaneous flap (TRAM), latissimus dorsi flap or free flap.
- Preparation of moulage for custom breast implant.
- Augmentation mammoplasty.
- Reduction mammoplasty.
- Mastopexy.

Services that do not meet the criteria of this policy will be considered not medically necessary.

Breast Prosthetics

The following breast prosthetics are medically necessary:

- Breast prosthesis, mastectomy bra.
- Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral.
- Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral.
- Breast prosthesis, mastectomy sleeve.
- Breast prosthesis, mastectomy form.
- Breast prosthesis, silicone or equal.

- Breast prosthesis, not otherwise specified.
- Adhesive skin support attachment for use with external breast prosthesis, each.
- External breast prosthesis garment, with mastectomy form, post mastectomy.
- Custom breast prosthesis, post mastectomy, molded to patient model.
- Implantable breast prosthesis, silicone or equal.
- Camisole, post-mastectomy.
- Breast prosthesis, silicone or equal, with integral adhesive.
- Nipple prosthesis, reusable, any type, each.

NOTE

When the implantable breast prosthesis is provided by the hospital, the charge should be billed as a hospital expense.

When the physician incurs the cost of the breast implant, the charge should be billed as a professional expense.

Charges for implantable breast prosthesis should be denied as cosmetic when the implant is provided in conjunction with a cosmetic augmentation mammoplasty.

Place of Service

Mastectomy and reconstructive surgery is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

The following indications for removal of implants are considered not medically necessary:

- Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases, etc.; or
- Patient anxiety; or
- Baker class III contractures in patients with implants for cosmetic purposes; or
- Rupture of a saline implant in patients with implants for cosmetic purposes; or
- Pain not related to contractures or rupture.

Implantable breast prosthesis billed in conjunction with a cosmetic augmentation mammoplasty is considered cosmetic and, therefore, noncovered and applies to Professional claims.

PROCEDURE CODES

Table	Style
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.
19301	Mastectomy, Partial (e.g., Lumpectomy, Tylectomy, Quadranectomy, Segmentectomy).
19302	Mastectomy, Partial (e.g., Lumpectomy, Tylectomy, Quadranectomy, Segmentectomy); With Axillary Lymphadenectomy.

19303	Mastectomy, Simple, Complete.
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	Breast Reduction.
19325	Breast Augmentation With Implant .
19328	Removal Of Intact Breast Implant.
19330	Removal Of Ruptured Breast Implant, Including implant Contents (e.g. Saline, Silicone Gel).
19340	Insertion of Breast Implant On Same Day Of Mastectomy (i.e., Immediate).
19342	Insertion or Replacement Of Breast Implant On Separate Day From Mastectomy.
19350	Nipple/aerola Reconstruction.
19357	Tissue Expander Placement In Breast Reconstruction, Including Subsequent Expansion(s).
19361	Breast Reconstruction; With Latssimus Dorsi Flap.
19364	Breast Reconstruction; With Free Flap (e.g., Ftram, Diep, Siea, Gap Flap).
19367	Breast Reconstruction; With Single-pedicled Transverse Rectus Abdominis Myocutaneous (tram) Flap.
19368	Breast Reconstruction; With Single-pedicled Transverse Rectus Abdominis Myocutaneous (tram) Flap, Requiring Separate microvascular Anastomosis (supercharging).
19369	Breast Reconstruction; With Bipedicled Transverse Rectus Abdominis Myocutaneous (tram) Flap.
19396	Preparation Of Moulage For Custom Breast Implant.
19499	Unlisted Procedure, Breast.

A4280	Adhesive Skin Support Attachment For Use with External Breast Prosthesis, Each.
L8000	Breast Prosthesis, Mastectomy Bra, Without Integrated Breast Prosthesis Form, Any Size, Any Type.
L8001	Breast Prosthesis, Mastectomy Bra, With Integrated Breast Prosthesis Form, Unilateral, Any Size, Any Type.
L8002	Breast Prosthesis, Mastectomy Bra, With Integrated Breast Prosthesis Form, Bilateral, Unilateral, Any Size, Any Type.
L8010	Breast Prosthesis, Mastectomy Sleeve.
L8015	External Breast Prosthesis Garment, With Mastectomy Form, Post Mastectomy.
L8020	Breast Prosthesis, Mastectomy Form.
L8030	Breast Prosthesis, Silicone Or Equal, Without Integral Adhesive.
L8031	Breast Prosthesis, Silicone Or Equal, With Integral Adhesive.
L8032	Nipple Prosthesis, Prefabricated, Reusable, Any Type, Each.
L8035	Custom Breast Prosthesis, Post Mastectomy, Molded To Patient Model.
L8039	Breast Prosthesis, Not Otherwise Specified.

Eligible Diagnosis codes for Procedure code 19303

Codes				
C50.011	C50.012	C50.019	C50.021	C50.021
C50.022	C50.029	C50.111	C50.112	C50.119
C50.121	C50.122	C50.211	C50.212	C50.219
C50.221	C50.222	C50.229	C50.311	C50.312
C50.319	C50.321	C50.322	C50.329	C50.411
C50.412	C50.419	C50.421	C50.422	C50.429
C50.511	C50.512	C50.519	C50.521	C50.522
C50.529	C50.611	C50.612	C50.619	C50.621
C50.622	C50.629	C50.811	C50.812	C50.819
C50.821	C50.822	C50.829	C50.911	C50.912
C50.919	C50.922	C50.929	D05.00-D05.02	E71.440
N60.00	N60.12	N61.19	N60.21	N60.22
N60.29	N60.31	N60.32	N60.41	N60.42

N60.49	N60.81	N60.82	N60.89	N60.91
N60.92	N60.99	Q85.8	R92.0-R92.2	S29.9XXA
T85.41XA	T85.41XD	T85.41XS	T85.42XA	T85.42XD
T85.42XS	T85.43XA	T85.43XD	T85.43XS	T85.44XA
T85.44XD	T85.44XS	T85.49XA	T85.49XD	T85.49XS
T85.79XA	T85.79XD	T85.79XS	Z15.01	Z15.09
Z80.3	Z80.41	Z85.3	Z92.3	Z98.890

POLICY UPDATE HISTORY

<Date>	<Event>