BREAST REPAIR/RECONSTRUCTION NOT FOLLOWING MASTECTOMY

Protocol: SUR058
Effective Date: March 1, 2017

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INSTRUCTIONS FOR USE

This protocol provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Evidence of Coverage (EOC)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this protocol. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Protocol. Other Protocols, Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Protocols, Policies and Guidelines as necessary. This protocol is provided for informational purposes. It does not constitute medical advice. This policy does not govern Medicare Group Retiree members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COMMERCIAL & MEDICARE COVERAGE RATIONALE

If the member’s condition meets the Women’s Health and Cancer Rights Act (WHCRA) criteria, please refer to the Breast Reconstruction Post Mastectomy Protocol.

Criteria for a coverage determination as reconstructive:

- Removal of breast implants with capsulotomy/capsulectomy for symptomatic capsular contracture is considered reconstructive when the following criteria are met:
  - Baker grade III or IV capsular contracture;

  **Baker Grading System for Capsular Contracture**
  - Grade I – breast is soft without palpable thickening
  - Grade II - breast is a little firm but no visible changes in appearance
- Grade III - breast is firm and has visible distortion in shape
- Grade IV - breast is hard and has severe distortion or malposition in shape; pain/discomfort may be associated with this level of capsule contracture (ASPS, 2005).
  - Limited movement leading to an inability to perform tasks that involve reaching or abduction. Examples include retrieving something from overhead, combing one’s hair, reaching out or above to grab something to stabilize oneself.

- Removal of a deflated saline breast implant shell is considered cosmetic unless the implants were done post-mastectomy. Refer to the Breast Reconstruction Post Mastectomy Protocol.
- Correction of inverted nipples is considered reconstructive when one of the following criteria are met:
  - Member meets the Women’s Health and Cancer Rights Act (WHCRA) criteria (refer to the Breast Reconstruction Post Mastectomy Protocol for details); or
  - Documented history of chronic nipple discharge, bleeding, scabbing or ductal infection.
  
  **Note:** Correction of congenital inverted nipples may be covered based on a state mandate or the enrollee’s specific benefit document. See Congenital Anomaly definition below.

- Revision of a reconstructed breast (CPT Code 19380) is considered reconstructive when the original reconstruction was done for mastectomy or other covered health service. (see Applicable Codes section below for a list of codes that meet the criteria for a reconstructed breast).
- Breast reconstruction done for Poland Syndrome (see definition below) is reconstructive. Although no functional impairment may exist for the breast reconstruction for Poland Syndrome, this has been deemed reconstructive surgery.
- Removal of a ruptured silicone gel breast implant is covered regardless of the indication for the initial implant placement.

**Additional Information**

Tissue protruding at the end of a scar (“dog ear”/standing cone), painful scars or donor site scar revisions must be reviewed to determine if the procedure meets reconstructive guidelines.

**Coverage Limitations and Exclusions**

Some states require benefit coverage for services that the health plan considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to the member specific benefit document.

- Cosmetic Breast Procedures are excluded from coverage. Examples include but are not limited to:
  - Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy).
  - Breast reduction surgery that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the Women’s Health and Cancer Right's Act.
  - Breast surgery only for the purpose of creating symmetrical breasts except when post mastectomy.
  - Breast prosthetics or replacement following a cosmetic breast augmentation.

- Revision of a prior reconstructed breast due to normal aging does not meet the definition of a covered reconstructive health service.
Centers for Medicare and Medicaid Services (CMS):
Medicare does not have a National Coverage Determination (NCD) for breast repair/reconstruction not following mastectomy. Local Coverage Determinations (LCDs) do not exist for Nevada at this time (Accessed January 2017).

For Medicare and Medicaid Determinations Related to States Outside of Nevada:
Please review Local Coverage Determinations that apply to other states outside of Nevada. http://www.cms.hhs.gov/mcd/search

Important Note: Please also review local carrier Web sites in addition to the Medicare Coverage database on the Centers for Medicare and Medicaid Services’ Website.

MEDICAID COVERAGE RATIONALE


Surgical procedures deemed experimental, not well established or not approved by Medicare or Medicaid are not covered and will not be reimbursed for payment. Below is a list of definitive non-covered services:

1. Cosmetic Surgery: The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the recipient’s preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or the improvement of a malformed body member which coincidentally services some cosmetic purpose. Examples of procedures which do not meet the exception to the exclusion are facelift/wrinkle removal (rhytidectomy), nose hump correction, moonface, routine circumcision, etc;

2. Breast reconstruction for cosmetic reasons, however breast reconstruction following removal of a breast for any medical reason may be covered.

DEFINITIONS

Congenital Anomaly: A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Functional/Physical Impairment: A physical/functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Poland Syndrome: A rare, nonfamilial anomaly of unknown cause. The components of the syndrome include absence of the pectoralis major muscle, absence or hypoplasia of the pectoralis minor muscle, absence of costal cartilages, hypoplasia of breast and subcutaneous tissue (including the nipple complex), and a variety of hand anomalies. The most common chest wall reconstructive...
procedure in Poland’s is rotation of the latissimus dorsi muscle to reconstruct the anterior chest wall deficiency and anterior axillary fold. Note: Poland Syndrome does not include tuberous breasts or developmental breast asymmetry.

**Reconstructive Procedures:** Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

**Reconstructive Surgery:** defined by the American Society of Plastic Surgeons, “is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.”

**Sickness:** Physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

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<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<tr>
<td>19328</td>
<td>Removal of intact mammary implant</td>
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<tr>
<td>19330</td>
<td>Removal of mammary implant material</td>
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<tr>
<td>19355</td>
<td>Correction of inverted nipples</td>
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<tr>
<td>19370</td>
<td>Open periprosthetic capsulotomy, breast</td>
</tr>
<tr>
<td>19371</td>
<td>Periprosthetic capsulectomy, breast</td>
</tr>
<tr>
<td>19380</td>
<td>Revision of reconstructed breast</td>
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**REFERENCES**

The foregoing Health Plan of Nevada/Sierra Health & Life Healthcare Operations protocol has been adopted from an existing UnitedHealthcare coverage determination guideline that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.