BREAST REPAIR/RECONSTRUCTION NOT FOLLOWING MASTECTOMY

Guideline Number: CDG.005.01
Effective Date: November 1, 2013

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INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs)) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee’s specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline does not constitute medical advice.

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.

COVERAGE RATIONALE

Plan Document Language
Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group:
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee’s specific plan document to determine benefit coverage.
Indications for Coverage

If the member’s condition meets the Women’s Health and Cancer Rights (WHCRA) criteria or applicable state mandates regarding post mastectomy (see Breast Reconstruction Post Mastectomy Coverage Determination Guideline), do not use this guideline.

1. Breast reconstruction done in conjunction with the repair of the chest wall deformity of Poland syndrome is reconstructive. Although no functional impairment may exist for the breast reconstruction for Poland syndrome, this has been deemed reconstructive surgery by legacy UnitedHealthcare plans and will continue to be deemed as such.

Additional Information:

Poland syndrome is 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.

2. Removal of a ruptured silicone gel breast implant is covered regardless of the indication for the initial implant placement.

3. All requests for a breast repair are subject to some level of review.

II. Criteria for a Coverage Determination as Reconstructive

A. Removal of breast implants with capsulectomy/capsulotomy for symptomatic capsular contracture is considered reconstructive when the following criteria are met:

   1. 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).

   2. 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.

B. Removal of a deflated saline breast implant shell is considered cosmetic unless the implants were done post-mastectomy. See Breast Reconstruction Post Mastectomy Coverage Determination Guideline.

C. Correction of inverted nipples is considered reconstructive when EITHER of the following criteria are met:

   1. Member meets the Women’s Health and Cancer Rights Act (WHCRA) criteria (see Breast Reconstruction Post Mastectomy Coverage Determination Guideline for details); OR

   2. Documented history of chronic nipple discharge, bleeding, scabbing or ductal infection.

D. Revision of a reconstructed (CPT Code 19380) breast is considered reconstructive when the original reconstruction was done for mastectomy or other covered health
service. See Coding section below for a list of codes that meet the criteria for a reconstructed breast.

**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.

**California Only:** this is the mandated language for Reconstructive Procedures: Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. 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 for cosmetic purposes only, but rather to improve function and/or create a normal appearance, to the extent possible.

**Coverage Limitations and Exclusions**

Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to enrollee’s plan specific documents.

1. Cosmetic Breast Procedures are excluded from coverage.
   
   a. Examples include but are not limited to:
      
      i. 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*)
      
      ii. 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
      
      iii. Breast surgery only for the purpose of creating symmetrical breasts except when post mastectomy.
      
      iv. Breast prosthetics or replacement following a cosmetic breast augmentation

2. Revision of a prior reconstructed breast due to normal aging does not meet the definition of a covered reconstructive health service.

### For ASO plans with SPD language other than fully-insured Generic COC language

Please refer to the enrollee’s plan specific SPD for coverage.

### DEFINITIONS

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

**Congenital Anomaly (California Only):** a physical developmental defect that is present at birth

**Cosmetic Procedures:** Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital...
Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UHC.

**Cosmetic Procedures (California Only):** procedures or services are performed to alter or reshape normal structures of the body in order to improve the Covered Person’s appearance

**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.

**Reconstructive Procedures:** Surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly, performed when a physical impairment exists and when the primary purpose of the procedure is to improve or restore physiologic functions. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

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. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

**Reconstructive Procedures (California Only):** Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. 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 for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

**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 Current Procedural Terminology (CPT®) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit 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 claims payment. Other policies and coverage determination guidelines may apply. 

*CPT® is a registered trademark of the American Medical Association.*
**Limited to specific procedure codes?**  
- **YES**  
- **NO**

<table>
<thead>
<tr>
<th>CPT® Procedure Code</th>
<th>Description</th>
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<tbody>
<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>
</tr>
<tr>
<td>19355</td>
<td>Correction of inverted nipples</td>
</tr>
<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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</tbody>
</table>

**The following CPT Codes meet the criteria for a Reconstructed Breast**

<table>
<thead>
<tr>
<th>CPT® Procedure Code</th>
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<tbody>
<tr>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
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<tr>
<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
</tr>
<tr>
<td>19357</td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
</tr>
<tr>
<td>19361</td>
<td>Breast reconstruction with latissimus dorsi flap, without prosthetic implant</td>
</tr>
<tr>
<td>19364</td>
<td>Breast reconstruction with free flap</td>
</tr>
<tr>
<td>19366</td>
<td>Breast reconstruction with other technique</td>
</tr>
<tr>
<td>19367</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), single pedicle, including closure of donor site</td>
</tr>
<tr>
<td>19368</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)</td>
</tr>
<tr>
<td>19369</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (tram), double pedicle, including closure of donor site</td>
</tr>
</tbody>
</table>

**Limited to specific diagnosis codes?**  
- **YES**  
- **NO**

**Limited to place of service (POS)?**  
- **YES**  
- **NO**

**Limited to specific provider type?**  
- **YES**  
- **NO**

**Limited to specific revenue codes?**  
- **YES**  
- **NO**

**REFERENCES**


**GUIDELINE HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<td>12/01/2010</td>
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<td>Date</td>
<td>Action/Description</td>
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<td>------------</td>
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<tr>
<td>02/01/2011</td>
<td>Moved exception language to the top of the guideline for ease of use.</td>
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<tr>
<td>09/01/2011</td>
<td>Updated footer. Updated definition of Reconstructive Procedures</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Annual Review. Updated on new template. Removed references to certificates of coverage. Codes reviewed, no changes made.</td>
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</table>
| 11/01/2013 | • Under Indications for Coverage removed the following: The following are considered exceptions and eligible for coverage as reconstructive without the required documentation listed below in Section I:  
  • Removed Required Documentation requirements.  
  • Under Coverage Limitations and Exclusion removed the following:  
    v. Hair removal or hair replacement  
    vi. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)  
    vii. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.  
    viii. Treatment for skin wrinkles or any treatment to improve the appearance of the skin  
    ix. Treatment of spider veins  
  • Removed the following language under Additional Information: Pain Questionnaire  
    1) Does the patient have contracture-related difficulty moving her upper arm during activities?  
       If yes, list the specific activities. Examples include retrieving something from overhead, combing one’s hair, reaching out or above to grab something to stabilize oneself.  
    2) Does the patient take over-the-counter medications (e.g., aspirin, ibuprofen, NSAIDS or a similar type of medication) or prescription medications for the pain?  
       If yes, what is the medication and dosage?  
  
Pain Questionnaire
If yes, how many days in a **two week period** of time did the patient take the medication?

- a) 0 - 2 days (0)
- b) 3 - 4 days (1)
- c) 5 - 6 days (2)
- d) 7 or more days (3)

**Scale for question 2 above:**
0 = no symptoms
1 = mild
2 = moderate
3 = severe
(If the member has a moderate or severe rating for question #2, she would meet the criteria.)

- Under II A, removed #2.
- Moderate or severe pain as indicated by answers to pain questionnaire (see below; OR

- Removed definition for High Color Photograph.
- Under Coverage Limitations and Exclusions #1, added the word “breast”

<table>
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<tr>
<td>04/11/2014</td>
<td>Reformatted table of contents (no change to policy content/coverage determination guidelines):</td>
</tr>
<tr>
<td></td>
<td>o Added new policy guideline number assignment for document archive management purposes; guideline number previously listed as CDG-A-030</td>
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<tr>
<td></td>
<td>o Removed applicable products grid (Note: Policy document no longer applies to Community Plan membership; Community Plan specific policy documents now available)</td>
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