Medical Policy & Procedure

Policy Name:	Medical Policy: Breast Reconstruction, Revision of Reconstruction, and Implant Removal and Replacement	Policy #:	MP-20

Policy Information	
Owner Department:	Medical Management Division
Owner:	Assigned Medical Director
Electronic Signature/Date:	Krystal Revai (01/15/2024), Lori Slaughter (01/11/2024)

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To make utilization decisions, Health Alliance uses written criteria based on sound clinical evidence for appropriately applying the criteria.

Statement of the Policy

To apply objective and evidence-based criteria when determining the medical appropriateness of health care services.

NOTE: Please refer to plan documents for prior authorization necessity/status.

Interpretations

Health Alliance uses Breast Reconstruction with Implant or Tissue Expander InterQual criteria to determine the medical necessity of this procedure. The InterQual criteria are available in the Utilization Management software system and can be accessed by providers when submitting an authorization digitally.

1. **When meeting InterQual Breast Reconstruction with Implant or Tissue Expander criteria—Operational Notes:**

1.1 After mastectomy, is defined as removal of **all or part** of the breast for medically necessary reasons.

1.2 Surgical **reconstruction of the opposite breast to provide a symmetrical appearance with the reconstructed breast is a covered benefit** for the member who has had a mastectomy (lumpectomy or complete). The reconstruction process may leave the opposite or contralateral breast larger or smaller than the surgical breast. To correct this asymmetry, a mastopexy or reduction mammoplasty may be performed on the contralateral breast. If the reconstructed breast is larger, then an augmentation mammoplasty with implant may be performed on the nondiseased breast.

1.3 There is no time frame in which the member is required to have the reconstruction performed post mastectomy

1.4 Interpretation of coverage under this policy is subject to the **Federal Women's Health and Cancer Rights Act of 1998** which requires that in patients with breast cancer or a history of breast cancer, all stages of reconstruction of the breast on which a mastectomy was performed, surgery and **reconstruction of the other breast to produce a symmetrical appearance**, prostheses, and treatment of physical complications of the mastectomy including lymphedema are considered medically necessary.

1.5 Health Alliance covers **autologous fat grafting** (CPT 15771, 15772, lipoaugmentation) **for primary breast reconstruction and for Revisions of Reconstructed Breasts (Criteria 3 below).**

1.6 Health Alliance considers the use of the following **acellular dermal matrices** medically necessary for breast reconstruction:

- Alloderm
- Alloderm-RTU
- DermACELL DermaMatrix
- FlexHD

1.7 Health Alliance covers **Nipple/areola reconstruction** (CPT 19350) and **Tattooing** (11920-11922) as part of reconstruction/revisions. When tattooing is not performed by a licensed medical specialist it will be covered when the breast surgeon refers the member to a specific, named tattoo artist.

2. Removal of an Existing Breast Implant: Do Not Use: InterQual Breast Implant Removal Criteria

2.1 Removal is covered if the original reconstruction qualified for coverage as Criteria 1 (Not when it was originally performed for augmentation) above, and:

2.2 There is a documented medical problem:

2.2.1 Leaking implant as demonstrated by imaging, or

2.2.2 Well-documented chronic pain related to recurrent breast infections, or

2.2.3 A Baker Grade III or IV contracture.

- Baker Contracture Classification
  - Grade 1 Augmented breast feels soft as a normal breast.
  - Grade II Augmented breast is less soft and implant can be palpated, but is not visible.
  - Grade III Augmented breast is firm, palpable and the implant (or distortion) is visible
  - Grade IV Augmented breast is hard, painful, cold, tender, and distorted.

2.2.4 Tissue necrosis secondary to the implant.

2.2.5 Diagnosed breast implant-associated anaplastic large cell lymphoma.

2.2.6 Current use of Allergan BIOCELL textured breast implants.

2.3 **Removal is NOT** covered for the following:

2.3.1 When implant is originally placed for augmentation

2.3.2 Member's weight changes.

2.3.3 Increased motion of the implant.

2.3.4 Patient anxiety or fear of the implant rupture or cancer.

2.3.5 Systemic conditions, such as:

- Connective tissue disease, or
- Autoimmune disease, or
- Rheumatic conditions, or
- Neurologic symptoms, or
- Fibromyalgia, or
- Chronic fatigue syndrome.

3. Health Alliance covers Revision of Reconstructed Breast (CPT 19380, e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction and/or autologous fat grafting, CPT 15771-15772) in the event of:

3.1 Breast asymmetry, or

3.2 Painful scars, or

3.3 Removal and replacement of implant if meet Criteria 2 above, or.

3.4 Breast contour deformities or visible implant rippling of skin.

4. Complications of or Removal and Replacement of Implant(s) Are Not Covered If:

4.1 The original procedure was for augmentation.

4.2 The original or subsequent replacement of implants did not meet criteria for coverage.

Medicare Advantage Criteria Details:

- **NCD - Breast Reconstruction Following Mastectomy (140.2) (cms.gov)**
- Enter NCD or Regional LCD/LCA ID in the Medicare website/link below for criteria details.
- MCD Search (cms.gov)

Regional Medicare Admin Contractor (MAC) – Member's state	Regional LCD/LCA Identifier	Applicable Criteria
NGS (IL)	None	NCD
Noridian (WA)	L37020/A57222	Applicable Noridian LCD/LCA
Palmetto (NC)	L33428/A56658	Applicable Palmetto LCD/LCA
WPS (IA, IN)	L39051/A58774	Applicable WPS LCD/LCA
CGS (OH)	L39506/A59299	Applicable CGS LCD/LCA

CPT Codes	
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)
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk
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 (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, 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
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19396	Preparation of moulage for custom breast implant

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. Women's Health and Cancer Rights Act of 1998
2. Bostwick III, J. Breast reconstruction after mastectomy: Recent Advances. Cancer, 1990: 66, 1402–1411.
3. Compliance Notice, Health Alliance Medical Plans, Fall 1998.
4. Field, DA, & Miller, S. Cosmetic breast surgery. *American Family Physician*. 1992: 45, 711–719.
5. Letter from William J. Washington, Chief Contracting Officer, United States Office of Personnel Management, received 07/05/96.
6. Memo from Robin Stoller, Associate Legal Counsel, 07/25/97, regarding HIPAA and Reconstructive Surgery.
7. Strategic Planning Committee, 03/07/97.
8. Amendment to Section 10 of the Health Maintenance Organization Act. See 215 ILCS 125/4-6.1 (Illinois Compiled Statutes Chapter), 4/10/02.
9. Reference section 1.4 - Definition of Mastectomy as defined in Illinois Law is: removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.
10. BCBS Illinois, Breast Implant, Removal and/or Insertion #SUR716.009, December 1, 2005
11. Aetna, Breast Implant Removal, Number: 0142, February 5, 2008
12. Illinois mandate for reconstructive surgery following mastectomy. (1998). 215 ILCS 5/356g.

History

Created Date:	03/14/90
Effective Date:	03/14/90

Next Review Date:	01/15/2025		
Revision Date:	06/90	12/11/91	10/14/92
	04/14/93	02/14/95	10/08/96
	04/01/97	10/28/97	10/27/98
	12/15/98	02/23/00	03/27/01
	04/10/02 – MDC	12/11/02 – MDC	01/28/03 –MPC
	04/09/03	03/10/04 – MDC	02/23/05 – MDC
	03/14/07 – MDC	11/02/07 – MDC	02/27/08 – MDC
	06/13/12 – MDC	07/09/13 – MDC	06/09/14
Reinstated Date:	06/09/15		
Revision Date:	02/10/16 – MDC-Delete two-year time-frame for Illinois members to have reconstruction post-mastectomy when no malignancy is found.		
	06/08/16 – MDC-Addition of language from Federal Women's Health and Cancer Rights Act of 1998.		
	05/10/17	12/13/17 – MDC-Revision to adjudicate this policy converted to a custom IQ Check sheet.	
	12/31/18 – MDC-Approved InterQual 8/21/18.		
	07/16/19 – MDC-Annual review, no change.		
	06/24/20 – MDC-Annual review, Clear Coverage language updated to Guiding Care/InterQual.		
	08/17/21 – MDC-annual review, additional operational language added, criteria for reconstructed breast, additional acellular dermal matrix products for reconstruction added, Federal Women’s Health Rights Act for Symmetry added, and coverage information for autologous fat grafting for revisions.		
	10/18/22 – MDC-Annual review, Medicare information updated, no changes.		
	11/21/23 – MDC-Annual review, nipple tattooing language added, removal of breast implant removal codes from InterQual auto-authorization due to no language for replacement due to augmentation.		