`

Medical Policy

Joint Medical Policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information.

Category: Surgery
***Current Policy Effective Date: 9/1/06**

Title: Breast Reconstruction

Procedure Code(s): Multiple

Description / Background

Breast reconstructive surgery is performed to improve or restore bodily appearance following mastectomy. Reconstructive surgery may also be required to correct congenital defects or breast defects that are a result of trauma. Breast reconstruction after mastectomy may also include prosthetic devices and other services. The goal is to return the breast(s) to a condition that closely mimics the original anatomical situation prior to the ablative surgical procedure. Surgical reconstruction of the affected breast after mastectomy also includes the treatment of complications from the original procedure.

In addition, breast reconstruction may include surgery on the non-affected breast (which may include breast reduction or augmentation) for achieving symmetry of the breast.

CPT / HCPCS Level II Codes and Description *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

11920	11921	11922	19160	19316	19318
19324	19325	19328	19330	19340	19342
19350	19357	19361	19364	19366	19367
19368	19369	19370	19371	19380	19396

*Check policy history boxes for previous effective dates

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

L8000	L8001	L8002	L8010	L8015	L8020
L8030	L8035	L8039	L8600		

Diagnoses / Medical Conditions:

- Malignant neoplasm of female breast
- Personal history of malignant neoplasms; breast (classified to 174 and 175)
- Family history of malignant neoplasm; breast (classifiable to 174)
- Acquired absence of breast
- Genetic susceptibility to malignant neoplasm of breast

Medical Policy Statement

The safety and effectiveness of breast reconstruction procedures have been established. They are considered useful therapeutic options when indicated.

Rationale

Breast reconstruction is established as a safe and effective procedure to improve or restore bodily appearance or to correct an anatomic impairment caused by an accidental injury or a prior medically necessary surgical procedure or disease.

Surgical procedures involved in breast reconstruction are established as safe and effective treatments regardless of when the mastectomy was originally performed, as long as the mastectomy meets criteria for covered conditions. If the mastectomy was medically necessary, the surgical services involved in reconstruction of one or both breasts are covered. Implantations of prosthetic devices are considered an integral part of breast reconstruction following any medically necessary mastectomy and include the removal or replacement of implants if needed

Medical Policy Position Summary (Non-clinical summary statement for customer use)

Surgical procedures involved in breast reconstruction are established as safe and effective treatments regardless of when the mastectomy was originally performed, so long as the mastectomy meets criteria for covered conditions. If the mastectomy was medically necessary, the surgical services involved in reconstruction of one or both breasts are covered. Breast reconstruction may also be medically necessary, not cosmetic, when done for congenital defects such as the complete absence of breast tissue, developmental abnormalities, trauma, infection or following other therapeutic surgical procedures.

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

Inclusions

- Trauma to the breast(s)
- Family or personal history of cancer of the breast
- Current diagnosis of breast cancer
- Congenital defects, such as breast agenesis
- Developmental abnormalities, infection, or following therapeutic surgery

Exclusions

- Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases, etc.
- Patient anxiety.
- Baker class III contractures in patients with implants for cosmetic purposes.
- Rupture of a saline implant in patients with implants for cosmetic purposes.
- Pain not related to contractures or rupture.
- Connective tissue disease
- Autoimmune disease
- Rheumatic disease
- Neurologic symptoms
- Fibromyalgia
- Chronic fatigue syndrome
- Patient anxiety

Related Policies

- Prophylactic Mastectomy
- Breast Implant Removal/Reinsertion
- Breast Reduction - Female

Medicare Information

Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective non-cosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §l862 (a) (l0) of the Social Security Act.)

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

References

- Blue Cross Blue Shield Association Medical Policy, "Prophylactic Mastectomy," Number 7.01.09, original policy date 12/1/95, last updated 2/03.
- Blue Cross Blue Shield Association Medical Policy, "Reconstructive Breast Surgery/Management of Breast Implants," Number 7.01.22, Original policy date 12/1/95, last updated 2/2/03.
- Centers for Medicare and Medicaid Services, National Coverage Determinations (NCDs), "Breast Reconstruction Following Mastectomy," last review date 6/24/06.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 3/20/06, the date the research was completed.

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
6/27/02	6/27/02	6/27/02	Joint policy established
11/18/03	N/A	N/A	Policy retired
9/1/06	7/10/06	07/03/06	Policy language reviewed. Policy re-retired.

Next Review: This is an established policy and no longer subject to periodic review

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 11/19/98	Revised: 8/20/01
BCBSM: N/A	Revised: N/A

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

BCBSM & BCN Proprietary and Confidential Information
This information is for use only in connection with Permitted Uses as defined in the Administrative Services Contract between the Health Plan and BCBSM as Control Plan and is subject to limitations on disclosure described therein.

JUMP MAINTENANCE POLICY
EXPANDED REFERENCE SECTION

Title: Breast Reconstruction

Date: June 20, 2006

Internal Contacts: D. P. O'Neal, MD
C. VanderRoest, RN

RESOURCES:

Information and/or Technology Assessments from:

☒ Medicaid
Medicaid will follow Medicare guidelines. Reconstruction of affected and contralateral unaffected breast following medically necessary mastectomy is considered a safe, non-cosmetic procedure. Medicare National Coverage Determinations Manual Chapter 1, Part 2, Sections 90-160.25 last reviewed 6/24/05.

☒ Hayes, Inc. (new technology)
No information was found on this topic.

☐ Hayes, Inc. (custom search)

☒ Blue Cross Blue Shield Association Medical Advisory Panel (MAP) / Blue Cross Blue Shield Association Technological Evaluation Center (TEC Document)
No information was found on this topic.

☒ Medical Policy Panel (MPP) / Blue Cross Blue Shield Association Medical Policy Reference Manual (MPRM)
Reconstruction breast surgery is considered medically necessary following a medically necessary mastectomy, accidental injury or trauma. Policy 7.01.22 last reviewed 2/2003.

☒ Independent Medical Consultant Review
Initial request sent April 29, 2006.
Second request sent May 12, 2006. We await a reply. Continue to await reply 6/7/06

BCBSM/BCN's Medical Policy Statement diverges from national source document(s):
☐ Yes ☒ No
If yes, note: ☐ Medicare ☐ TEC ☐ MAP
Rationale for divergence:

CPT/HCPCS Level II Codes and Description:

Established codes:

11920 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0sq cm or less

*Check policy history boxes for previous effective dates

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

11921	Tattooing, intradermal introduction of insoluble opaque pigments t correct color defects of skins, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skins, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure)
19160	Mastectomy, partial (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19316	Mastopexy
19318	Reduction mammoplasty
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, 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
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, with or 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 abdominus myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulectomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
L8000	Breast prosthesis, mastectomy bra
L8001	Breast prosthesis, mastectomy bra w/ integrated breast prosthesis form, unilateral
L8002	Breast prosthesis, mastectomy bra, w/ integrated breast prosthesis form, bilateral
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
L8035	Custom breast prosthesis, molded to patient model
L8039	Breast prosthesis, NOC
L8600	Implantable breast prosthesis, silicone or equal

Administrative Modifications:

☐ Administrative modifications to be made (e.g., system changes

Addition of diagnosis code V84.01Genetic susceptibility to malignant neoplasm of breast.

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

BLUE CROSS BLUE SHIELD OF MICHIGAN
BLUE CARE NETWORK
JOINT MEDICAL POLICY

Name of Service: **Breast Reconstruction**

Recommendation: **The safety and effectiveness of breast reconstruction procedures have been established. They are considered useful therapeutic options when indicated.**

Signature on File

Jerry A. Johnson, MD
Senior Associate Medical Director
Blue Cross Blue Shield of Michigan

07/10/06

Signature Date

9/1/06

Policy Effective Date

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

BLUE CROSS BLUE SHIELD OF MICHIGAN
BLUE CARE NETWORK
JOINT MEDICAL POLICY

Name of Service: **Breast Reconstruction**

Recommendation: **The safety and effectiveness of breast reconstruction procedures have been established. They are considered useful therapeutic options when indicated.**

Signature on File

_____

William Granger, MD
Regional Medical Director
Blue Care Network of Michigan

07/03/06

_____

Date

9/1/06

_____

Policy Effective Date

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.

BLUE CARE NETWORK
POLICY: BREAST RECONSTRUCTION

I. Coverage Determination:

Surgical procedures involved in breast reconstruction are considered covered benefits regardless of when the mastectomy was originally performed. If the mastectomy was medically necessary, the surgical services involved in reconstruction of one or both breasts are covered. Implanted prosthetic devices are covered following any medically necessary mastectomy and include the medically necessary removal or replacement of implants.

II. Benefit Information:

Individual contract and/or certificate language will need to be checked for approved diagnoses and specific limitations.

III. Benefit Exclusions:

Members not meeting patient selection criteria.

IV. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Appropriate copayments will apply.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.
- Payment is based on BCN payment rules, individual certificate benefits and certificate riders.

V. Effective Date:

Policy updated and retired: 9/1/06
Joint policy effective date: 6/27/02
Supersedes BCN benefit information of: 8/20/01, 11/19/98

BCBSM/BCN Medical Policies are developed to provide general information about Blue Cross Blue Shield and Blue Care Network of Michigan medical policies. This policy is not intended to offer coverage or medical advice. This policy may be updated and is therefore subject to change.