

**Medical Policy
Breast Surgeries**

	Commercial and Qualified Health Plans	MassHealth
Authorization required Breast Reconstruction Surgeries; Reduction Mammoplasty, Female Members; Breast Implant Removal; Mastopexy; Mastectomy♦; Augmentation mammoplasty; Nipple Repair; and Reduction Mammoplasty, Male Members	X	X
No notification or authorization Lumpectomy*	X	X

♦ Mastectomy due to gynecomastia requires Prior Authorization, No prior authorization is required on other mastectomy procedures except for mastectomy as a component of staged gender affirmation treatment or gynecomastia surgery.

*Elective inpatient admissions require prior authorization. Outpatient surgery resulting in inpatient admissions requires notification.

Overview

The purpose of this document is to describe the guidelines AllWays Health Partners utilizes to determine medical appropriateness for breast surgery. The treating specialist must request prior authorization for breast surgery procedures. Prior authorization is required for all breast reduction and reconstruction surgeries, implant removal, nipple repair, and gynecomastia surgery and for mastectomy/lumpectomy procedures requiring an inpatient admission.

Coverage Guidelines

Breast Reconstruction Surgery

AllWays Health Partners covers breast reconstruction, augmentation, reduction, implant removal, and gynecomastia surgery when it is recommended by the member’s primary care physician or referring surgeon, the requested procedure can reasonably be expected to resolve the medical condition or complication and functional impairment, and the request meets medical necessity criteria indicated below. AllWays Health Partners reserves the right to deny coverage for any breast surgery procedures that:

1. Do not meet coverage criteria;
2. Are not in accordance with the Women’s Health and Cancer Rights Act of 1998 (WHCRA);
3. Are considered cosmetic, performed primarily to improve a person’s appearance, and not medically necessary.



Breast Reconstruction Related to Breast Cancer Treatment

AllWays Health Partners covers mastectomy/lumpectomy for cancer and for cancer-related prophylaxis in accordance with the benefits described in the individual benefit handbook or coverage of benefits when the attending physician determines that mastectomy is medically necessary. This includes prophylactic mastectomy for BRCA carriage or another well-defined genetic predisposition to breast cancer.

AllWays Health Partners covers breast reconstruction in accordance with the Women's Health and Cancer Rights Act of 1998. AllWays Health Partners provides coverage for:

- Reconstruction of the breast on which a mastectomy/lumpectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prosthesis and treatment of physical complications at all stages of a mastectomy/lumpectomy, including lymphedema; and
- Tattooing of an areola as part of a nipple reconstruction following mastectomy/lumpectomy.

Breast Reconstruction Related to Gender Affirming Procedures

AllWays Health Partners covers medically necessary mastectomy or breast augmentation mammoplasty for gender dysphoria when a member meets relevant medical necessity criteria for coverage under the [Gender Affirming Procedures](#) medical policy.

Breast Reconstruction Related to Other Medical Conditions (photo documentation is required)

AllWays Health Partners covers medically necessary breast reconstruction surgery including but not limited to augmentation, reduction mammoplasty, and mastopexy in the following instances:

1. For treatment of a member with:
 - a. Severe disfigurement due to congenital chest wall deformities causing functional impairments such as in Poland syndrome; OR
 - b. Repair of severe breast asymmetry due to acute trauma

Reduction Mammoplasty, Female Members (photo documentation is required)

As of February 20, 2017, medical necessity for reduction mammoplasty in female members is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

AllWays Health Partners considers members <18 years of age eligible for reduction mammoplasty when they have reached full physical maturity i.e. tanner stage V, typically age 15 and older and when all other InterQual® criteria are met.

Mammogram Requirements

Only women fifty years or older must have a negative mammogram for cancer performed within two years prior to the date of the planned surgery. This must be evidenced by one of the following:

- i. Copy of the mammogram report;
- ii. Verbal or written confirmation from a MD/RN/PA in the surgeon's or PCP's office; or
- iii. Verbal report from office support staff following instructions from MD/RN/PA (one of whom has reviewed the report).



Note: Coverage for reduction mammoplasty is limited to one procedure per member per lifetime.

Breast Implant Removal

As of February 20, 2017, medical necessity for breast implant removal is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Nipple Repair

AllWays Health Partners covers medically necessary nipple repair when there is medical record documentation supporting the following:

1. An inverted nipple is causing a demonstrated inability to breast feed and the requested procedure can reasonably be expected to restore this lost functionality; and
2. Other nipple procedures are authorized when they are medically necessary part of an AllWays Health Partners authorized breast reconstruction procedure.

Reduction Mammoplasty, Male (Gynecomastia Surgery) (photo documentation is required)

As of February 20, 2017, medical necessity for reduction mammoplasty in male members is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions

AllWays Health Partners does not provide coverage for breast surgery for conditions that do not meet the criteria noted, including but not limited to:

1. Breast surgeries or procedures performed solely to enhance a member's appearance or to counteract appearance that occurs through the natural aging process, in the absence of any signs or symptoms of functional abnormalities and/or associated medical complication is considered cosmetic and is not a covered benefit, unless specifically noted in the coverage criteria.
2. Breast surgeries or procedures performed primarily for psychological or emotional reasons.
3. Mastopexy for breast reconstruction unless it is for cancer-related mastectomy/lumpectomy or severe deformity due to Poland's syndrome or breast trauma.
4. Removal of a breast implant that has been placed for cosmetic purposes is not a covered benefit when performed due to:
 - a. Pain without clearly defined abnormalities on exam or radiographically that meet the criteria above;
 - b. Leakage of a saline implant; or
 - c. Anxiety concerning a potential complication.
5. Replacement of an implant that has been removed for medical necessity that had been originally placed for cosmetic purposes is not a covered benefit.
6. Surgical treatment for gynecomastia is not considered medically necessary for any of the following reasons:
 - a. There is laboratory drug screen evidence of illicit substance abuse that can cause gynecomastia (e.g. marijuana, heroin, amphetamines);
 - b. There is a history of chronic alcohol abuse;

- c. There is a history of the use of supplements/herbal products/hormones that can cause gynecomastia, and which have not been prescribed by a licensed clinician to treat a medical condition; or
 - d. Treatment of pseudogynecomastia (breast enlargement secondary to fatty tissue).
7. Breast surgeries not specifically noted as covered procedures in this medical policy or in the [Gender Affirming Procedures Policy](#).
8. Subsequent breast surgeries that are not part of an approved staged reconstruction plan and are intended for the sole purpose of cosmetic enhancement.

Definitions

Capsular contracture- Baker Scale:

- Grade I — the breast is normally soft and appears natural in size and shape
- Grade II — the breast is a little firm, but appears normal
- Grade III — the breast is firm and appears abnormal
- Grade IV — the breast is hard, painful to the touch, and appears abnormal

Gynecomastia: Abnormal proliferation of breast tissue in males.

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales

- Grade I Small breast enlargement with localized button of tissue that is concentrated around the areola.
- Grade II Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
 - Grade IIA Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest without skin redundancy
 - Grade IIB Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy
- Grade III Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present.
- Grade IV Marked breast enlargement

Breast Reduction Table: Based on a table adapted from a study by Schnur (1991).

Regulation

Women's Health and Cancer Rights Act of 1998

Sec. 713. Required Coverage for Reconstructive Surgery Following Mastectomies.

- (a) In General - A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:
- All stages of reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.
- (b) **Notice** - A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance 1078 with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted:
- In the next mailing made by the plan or issuer to the participant or beneficiary;
 - As part of any yearly informational packet sent to the participant or beneficiary; or
 - Not later than January 1, 1999; whichever is earlier.
- (c) **Prohibitions** - A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not:
- Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and
 - Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. 1079
- (d) **Rule of Construction** - Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

Related Policies

- [Reconstructive and Cosmetic Procedures](#)
- [Gender Affirming Procedures](#)
- [Dermatology Provider Payment Policy Guideline](#)

CPT/HCPC Codes

Authorized Codes	Code Description
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)
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
19300	Mastectomy for gynecomastia
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
19355	Correction of inverted nipples
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, 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 abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of mouldage for custom breast implant

Effective

December 2020: Off-cycle review. Updated Table on Page 1. Revised Coverage Guidelines criteria to create separate subheadings and criteria for Reconstruction Surgery, Breast Reconstruction Related to Breast Cancer Treatment, Breast Reconstruction Related to Gender Affirming Procedures, and Breast Reconstruction Related to Other Medical Conditions. Under Exclusions, revised “Mastopexy for breast

reconstruction unless it is for cancer related mastectomy/lumpectomy” to state “Mastopexy for breast reconstruction unless it is for cancer-related mastectomy/lumpectomy or severe deformity due to Poland’s Syndrome or Breast Trauma”. Under Definitions section, removed Cup Size.

January 2020: Annual Review. Updated references.

January 2019: Annual Review.

April 2018: Added codes.

December 2017: Annual review.

May 2017: Added “photo documentation is required” to subheads Reduction Mammoplasty, Female Members, and to Reduction Mammoplasty, Male (Gynecomastia Surgery).

February 2017: Changes reflect the addition of InterQual® breast reconstruction surgeries, breast implant removal, reduction mammoplasty (male), reduction mammoplasty (female), and mastectomy criteria.

September 2016: Annual review.

September 2015: Coverage for ruptured saline implant removal and replacement when placed for certain medical conditions, clarity regarding overlap and consistency with Gender Reassignment Surgery Medical Policy added

September 2014: New medically necessary indicators added.

May 2013: Added physical maturity to breast reduction criteria; added breast implant removal & surgery for gynecomastia criteria.

June 2012: No change.

May 2011: Annual Review.

April 2010: Annual Review.

April 2009: Annual Review.

April 2008: Annual Review.

April 2007: Annual Review.

May 2006: Annual Review.

May 2005: Effective date.

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399 Revolution Drive, Suite 810, Somerville, MA 02145 | allwayshealthpartners.org



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