Clinical Policy: Breast Procedures (Cosmetic, Reconstructive and Length of Stay)

Reference Number: OK.CP.MP.500
Date of Last Revision: 04/24 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy provides medical necessity guidelines regarding breast cosmetic and reconstructive surgery and associated length of stay. The Medical Director has the final decision to deny coverage for services deemed cosmetic in nature and not medically necessary.

Note: *For other cosmetic procedures, refer to OK.CP.MP.31 Cosmetic and Reconstructive Procedures.*

Policy/Criteria

I. It is the policy of Ambettter of Oklahoma® that the following procedures and care related to the treatment of breast cancer and other breast conditions and are **medically necessary**:
   A. Inpatient care for at least forty-eight (48) hours following a mastectomy and at least twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer (unless the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate);
   B. Reconstructive breast surgery performed as a result of a partial or total mastectomy, including:
      1. Reconstruction of the diseased breast;
      2. All stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the nondiseased breast occur within twenty-four (24) months of the diseased breast.

II. It is the policy of Ambettter of Oklahoma® that breast surgeries are considered *cosmetic* and **not medically necessary** and are generally not a covered benefit when performed to improve a patient's normal appearance and self-esteem. These procedures include, but are not limited to:
   A. Breast augmentation;
   B. Revision, removal, or replacement of breast implants previously placed for cosmetic reasons;
   C. Removal of excess skin or body contouring procedures following weight loss or bariatric surgery when removal is solely cosmetic;
   D. Correction of inverted nipples;
   E. Breast reconstruction for fibroadenomas or other benign lesions, unless medically necessary per clinical decision support criteria.

Background

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, previous or concurrent surgeries, trauma, infection, tumors, or disease. It is generally performed to improve the functioning of a body part and may or may not restore a normal appearance. Functional impairment is a health condition in which the normal function of a part of the body or organ system is less than age appropriate at full capacity, such as decreased range of motion, diminished eyesight, or hearing, etc. that variably impacts activities of daily living.

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the appearance and self-esteem of a patient. It is generally not considered medically necessary.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Codes That Support Coverage Criteria

Inclusion

CPT Codes Codes	Description
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
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)

CPT Codes Codes	Description
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
19499	Unlisted procedure, breast

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	12/21	12/21
Annual review with no changes	12/22	12/22
Annual review with no changes	04/24	04/24

References

1. Oklahoma Statutes. Title 36. Insurance. Section 6060.5 – Oklahoma Breast Cancer Patient Protection Act. Oklahoma Breast Cancer Patient Protection Act (oscn.net)

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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