

UPMC Health Plan POLICY AND PROCEDURE MANUAL

POLICY NUMBER: PAY.046
REVISION DATE: 5/2009
ANNUAL APPROVAL DATE: 8/2009
PAGE NUMBER: 1 of 5

SUBJECT: Breast Reconstruction Procedures
INDEX TITLE: Medical Management
ORIGINAL DATE: April 2007

This policy applies to the following lines of business: (Check those that apply.)

Commercial:					
HMO ()		POS ()		PPO ()	
Fully Insured ()		Self-funded/ASO ()		HSA ()	
Medicare Select ()		Medicare Supplement ()			
DPW-MA:					
Health Choices ()				Voluntary ()	
CMS-MA:					
OH ()		WV ()		PA ()	
HMO (X)		PPO (X)		Specialty Needs Plan (X)	
				Part D ()	
				PFFS (X)	
				All (X)	
				Other ()	
				All ()	
PID-CHIP:					
Free ()				Sub ()	
				All (X)	
APPLICABLE TO:					
Community Care ()				Work Partners ()	

I. POLICY

It is the policy of UPMC Health Plan to cover Breast Reconstructive Procedures when it is medically necessary as detailed in this policy and covered under the member's specific benefit plan

This policy is in accordance with the Federal Women's Health and Cancer Rights Act of 1998 which states that coverage provided for the surgical procedure known as mastectomy "shall also include coverage for prosthetic devices and reconstructive surgery incident to any mastectomy".

II. DEFINITIONS

N/A

III. PURPOSE

The purpose of this policy is to define indications for coverage of breast reconstruction procedures.

IV. SCOPE

This policy applies to various UPMC Health Plan departments as indicated by the Benefit and Reimbursement Committee. These include but are not limited to Medical Management, Benefit Configuration and Claims departments.

V. PROCEDURE

A. Medical Description

Breast Reconstructive Surgery is defined as procedures of the breast and procedures to restore symmetry of the opposite breast (i.e. reconstruction, mastectomy, breast augmentation, mastopexy, prosthesis insertion/removal, and nipple tattooing to recreate the nipple and/or areola).

Cosmetic surgery is surgery performed to re-shape normal structures of the body in order to improve the individual's appearance and self-esteem.

B. Specific Indications

1. **Breast Reconstruction**

All stages of breast reconstruction of the breast and procedures of the opposite breast to restore symmetry, including treatment of complications is considered medically necessary following a medically necessary mastectomy.

2. **Nipple Tattooing**

Nipple tattooing is covered when performed as a part of covered breast reconstruction procedures.

3. **Capsulectomy**

Capsulectomy is covered for complications of implant rupture or when other medical complications occur.

4. **Breast Implantation:**

Breast implantation is covered when placed for reconstructive purposes following a mastectomy

5. **Removal and/or Revision or Re-Implantation of Breast Implant**

Removal and/or revision of a breast implant are covered, on a case-by-case basis, when medically necessary for any of the following conditions:

- Implant failure, leakage, rupture, or rejection;
- Interference with the diagnosis of breast cancer
- Infection
- Granuloma or siliconoma
- Trauma

- Hematoma
- Ischemia
- Painful capsular contracture causing severe discomfort and disfigurement
- Skin loss or extrusion of the prosthesis through the muscle area.

C. Limitations

1. Breast Reconstruction (breast implantation, removal or revision) for any of the following conditions is not medically necessary and therefore **not covered**:
 - When a breast procedure is done for cosmetic purposes (i.e., to improve appearance, shifting incorrect implant size, visible scars, uneven appearance, and wrinkling),
 - When done for anxiety over possible implant-associated disease,
 - When done for changes in breast and/or nipple sensation,
 - When the member has symptoms or a diagnosis of an auto-immune disorder, and there is no documentation of a medical condition,
 - For medical complications not indicated in this policy,
 - For placement of non-FDA approved breast implants.
2. Re-implantation of breast implants is **not covered** except when related to a cancer diagnosis.

D. Variations

N/A

E. Quality Audit

Quality Audit may monitor policy compliance or billing accuracy at the request of the UPMC Health Plan's Technology Assessment Committee or the Benefits Reimbursement Committee.

F. Information Required for Review Post Procedure Audit

Breast Implantation or Revision

Documentation should include all of the following:

1. A complete history and physical,
2. Diagnosis and purpose of requested surgery,
3. Photographs may be requested by the Medical Director.

Removal of Breast Implant

In addition to the above documentation, the following documentation should also be provided for removal of breast implant:

1. Why the implant has failed,
AND
2. Why the implant needs to be removed.

Re-Implantation of Breast Implant

In addition to the above documentation, the following documentation should also be provided for re-implantation of breast implant

- 1 Any pertinent documentation such as radiograph reports that will help support the medical necessity for the proposed procedure;
- 2 The medical record should present clear clinical evidence of the indication for the removal of the implant (s) and re-implantation.

H. References

1. Schnum PL, Schnur DP, Petty PM, et al. Reduction Mammoplasty: An Outcome Study. *Plastic & Reconstructive Surgery*. 1997; 100(4): 875-83.
2. Courtiss EH. Reduction mammoplasty by suction alone. *Plast Reconstr Surg* 1993; 92(7):1276-1284.
3. Gray LN. Liposuction breast reduction. *Aesth Plast Surg* 1998;22:159-162
4. Laws of Pennsylvania , session of 1997, Act 1997-51, section 633 Mastectomy and Breast Cancer Reconstruction
5. American Society of Plastic Surgeons (ASPS), Definitions of Cosmetic and Reconstructive Surgery, <http://www.plasticsurgery.org/>
6. Federal Act of 1998 Women's Health and Cancer Act.
7. Highmark Medicare Services: Breast Reconstructive Surgery, LCD No. L21502, retired 12/20/07.

Disclaimer:

UPMC Health Plan medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of UPMC Health Plan and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

UPMC Health Plan reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

These policies are the proprietary information of UPMC Health Plan. Any sale, copying, or dissemination of said policies is prohibited.