Subject: Breast Surgeries

Authorization:

Prior authorization is required for breast surgery procedures requested for members enrolled in HPHC commercial (HMO, POS, or PPO) products. Prior authorization is not required for mastectomy procedures including prophylactic mastectomy.

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation and/or color photographs may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation —via HPHConnect Clinical Upload or secure fax (800-232-0816)
- Photographs— HPHConnect Clinical Upload function, email (utilization_requests@harvardpilgrim.org), or mail (Utilization Management, 1600 Crown Colony Dr., Quincy, MA 02169). Please note that photographs should not be faxed as faxed photos cannot be utilized in making a medical necessity determination.

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Resources and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here.) Members may access these materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

Policy and Coverage Criteria:

For this policy, Harvard Pilgrim Health Care (HPHC) draws upon the following InterQual® criteria:

- Reduction Mammoplasty, Female (Version 2021)

For this policy, Harvard Pilgrim Health Care (HPHC) draws upon InterQual® criteria, which HPHC has customized:

- Breast Implant Removal (Version 2021)
- Breast Reconstruction for Breast Reconstruction with Implant or Tissue Expander (Version 2021)
- Breast Reconstruction for Breast Reconstruction with Autologous Tissue Reconstruction or Fat Grafting (Version 2021)

In addition, HPHC requires the following criteria:

Breast Reconstruction

- Colored photographs must be mailed or emailed to HPHC as faxed photos cannot be utilized in determination of medical necessity; AND
- Documentation confirms member meets ANY of the following criteria for Poland syndrome with severe breast disfigurement:
    - Chest wall defects in which the chest viscera are exposed, OR
    - The member has a functional impairment (e.g. respiratory compromise, exercise intolerance) secondary to Poland Syndrome.

Breast Implant Removal

Harvard Pilgrim Health Care (HPHC) considers post-mastectomy/post-lumpectomy implant removal as reasonable and medically necessary when documentation confirms procedure is requested to repair or restore the appearance of one or both breasts, or for physical complications after ANY stage of mastectomy, lumpectomy or excisional biopsy.

Harvard Pilgrim Health Care (HPHC) considers removal of a silicone or saline breast implant, with or without capsulectomy/capsulotomy, as reasonable and medically necessary when documentation confirms ANY of the following:

- Implant interferes with breast cancer screening
- Removal is needed to facilitate breast cancer treatment
- Removal is required to treat a persistent or recurrent infection (local or systemic) that is secondary to the breast implant, and refractory to medical management including antibiotics
- Removal is required to treat a capsular contracture (Baker Grade III-IV) that is causing pain and is refractory to medical management
- Removal of a ruptured silicone breast implant (intracapsular or extracapsular rupture) when rupture is confirmed by diagnostic imaging (e.g., MRI or other conclusive study).

Removal of a ruptured saline implant is considered not medically necessary in the absence of other complications.

When criteria for the removal of a unilateral breast implant are met, removal of the contralateral implant is authorized only if the procedure independently meets implant removal criteria (above).

Colored photographs must be mailed or emailed to HPHC as faxed photos cannot be utilized in determination of medical necessity.

Exclusions:

Harvard Pilgrim Health Care (HPHC) considers the listed breast surgeries as not medically necessary for all other indications. In addition, HPHC does not cover:

- Cosmetic procedures (e.g., mastopexy, correction of inverted nipple) that are not part of an authorized post-mastectomy breast reconstruction procedure,
- Removal of intact breast implants solely for a suspected benefit for prophylaxis against autoimmune disease, connective tissue disease or breast cancer,
- Removal of an intact breast implant solely because it has shifted
- Liposuction for breast surgery procedures

Coding:

Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

CPT® Code	Description
19316	Mastopexy
19318	Reduction mammaplasty
19325	Mammaplasty, 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/areolar 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, with or without prosthetic implant
19364	Breast reconstruction with free flap
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

Billing Guidelines:

Member's medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

References:

1. American Society of Plastic Surgeons (ASPS). Practice Parameter. Treatment Principles of Silicone Breast Implants. March 2005. Available at: http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/TreatmentPrinciplesofSiliconeBreastImplants.pdf.
2. Breast Reconstruction for Deformities Unrelated to Cancer Treatment: ASPS Recommended Insurance Coverage Criteria for Third-Party Payers): http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Breast-Reconstruction-for-Deformities-Unrelated-to-Cancer-Treatment.pdf
3. Contralateral prophylactic mastectomy. UpToDate.com/login [via subscription only]. Accessed August 4, 2021.
4. Local Coverage Determination for Cosmetic and Reconstructive Surgery (L34698). https://www.cms.gov/medicare-coverage-database/details/lcd-

details.aspx?LCDId=34698&ver=21&DocType=Active&bc=AAIAAAAAAAAAAA%3d%3d&. Accessed August 4, 2021.
5. Overview of breast reconstruction. UpToDate.com/login [via subscription only]. Accessed August 4, 2021.
6. Overview of breast reduction. UpToDate.com/login [via subscription only]. Accessed August 4, 2021.
7. Reduction mammoplasty - the sliding scale revisited. Ann Plastic Surg, Jan 1999; 42(1) 109-108.
8. Reduction Mammoplasty: ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Accessed August 4, 2021. http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Reduction_Mammaplasty_Coverage_Criteria.pdf
9. Reduction mammoplasty: cosmetic or reconstructive procedure'. Schnur, Paul L, et al., "Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?" Ann Plastic Surg. Sept 1991; 27 (3): 232-7.

Relevant Mandates:

- U.S. Women's Health and Cancer Right Act of 1998
- Maine Title 24-A MRSA 4237
- NH RSA 417-D:2-b
- MA Chapter 223

Summary of Changes

Date	Changes
7/21	No criteria changes; coding updated
1/21	Annual review; no changes
2/20	Annual review; no changes
4/19	InterQual® criteria adopted; criteria revised
2/19	No changes
1/19	Annual update; criteria and exclusion statements revised
11/17	Updated for style guide
10/16	Added language to support mandate for HIV associated lipodystrophy
5/16	Minor formatting edits. Updated references
6/15	Reformatted, minor language changes. Add coding profile. Add ASPS documents to references. Delete coverage for repair of inverted nipple unless part of an authorized post-mastectomy breast reconstruction procedure

Approved by Medical Policy Committee: 07/20/21
Approved by Clinical Policy Operational Committee: 9/02, 10/03, 10/04, 12/05, 1/06, 2/07, 2/08, 3/08, 4/09, 4/10, 5/11, 4/12, 4/13, 6/14, 6/15; 5/16; 10/16; 11/17; 1/19; 2/19; 4/19; 5/20, 2/21; 8/21
Policy Effective Date: 08/09/21
Initiated: 7/01