Medical Necessity Guidelines: Breast Reconstruction for Severe Breast Asymmetry

Effective: April 12, 2017

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Applies to:

☑ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409  
☐ Tufts Health Public Plans products  
   ☐ Tufts Health Direct — Health Connector; Fax: 888.415.9055  
   ☐ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055  
   ☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607  
   ☐ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404  
☐ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Coverage of breast reconstruction after mastectomy is covered without prior authorization according to the Women's Health and Cancer Rights Act (WHCRA).

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided 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 treatment of physical complications of all stages of the mastectomy, including lymphedema

COVERAGE GUIDELINES

This guideline is used to determine coverage of breast reconstructive surgery, not related to previous mastectomy, for Members whose plan documents include this benefit.

Tufts Health Plan may authorize coverage of breast reconstruction for female members, with severe breast asymmetry when medical record documentation confirms both of the following:

- The Member is aged 16 years or older who has reached physical maturity
- The Member has a diagnosis of severe breast asymmetry. Severe breast asymmetry, for the purpose of this guideline is defined as at least a 2-cup difference in breast size (e.g., one breast measures a cup size of A with the other breast measuring a cup size of C).

CODES

The following CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19318</td>
<td>Reduction Mammaplasty</td>
</tr>
<tr>
<td>19324</td>
<td>Mammaplasty, augmentation; without prosthetic implant</td>
</tr>
<tr>
<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant</td>
</tr>
</tbody>
</table>

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1 Breast reconstruction following mastectomy or breast lumpectomy is covered without prior authorization.

The above CPT procedure codes are only covered with the following ICD-10 diagnoses:

**ICD-10 Diagnosis**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>N62</td>
<td>Hypertrophy of breast</td>
</tr>
<tr>
<td>N64.2</td>
<td>Atrophy of breast</td>
</tr>
<tr>
<td>N64.82</td>
<td>Hypoplasia of breast (tubular breast)</td>
</tr>
</tbody>
</table>

**REFERENCES**


**APPROVAL HISTORY**

May 14, 2014: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC) for a October 1, 2014 effective date

Subsequent endorsement date(s) and changes made:

- April 8, 2015: Reviewed and renewed by IMPAC; no changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- March 17, 2016: Coding updated; ICD-9-CM codes removed
- April 13, 2016: Reviewed by IMPAC, renewed without changes
- April 12, 2017: Reviewed by IMPAC, renewed without changes
- July 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017

**Background, Product and Disclaimer Information**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLink℠ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

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