Coverage of any medical intervention discussed in a WellFirst Health medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

Breast Reconstruction Surgery MP9476

Covered Service: Yes

Prior Authorization Required: See policy

Additional information: For prophylactic mastectomies see MP9449 Prophylactic Mastectomy. For breast surgeries see MP9026 Breast Surgeries.

WellFirst Health Medical Policy:

1.0 Breast reconstruction procedures following mastectomy and lumpectomy that results in significant deformity (e.g. mastectomy or lumpectomy for treatment of or prophylaxis for breast cancer and mastectomy or lumpectomy performed for chronic, severe fibrocystic breast disease) do not require a prior authorization and are considered medically necessary for the following:

1.1 Breast reconstruction performed on the diseased/affected breast (e.g. breast on which the mastectomy/lumpectomy was performed), including:

1.1.1 Areolar and nipple reconstruction

1.1.2 Areolar and nipple tattooing

1.1.3 Autologous fat transplant (e.g. lipoinjection, lipofilling, lipomodeling)

1.1.4 Breast implant removal and subsequent reimplantation

1.1.5 Capsulectomy

1.1.6 Capsulotomy

1.1.7 Implantation of tissue expander

1.1.8 Implantation of U.S. Food and Drug Administration (FDA)-approved internal breast prosthesis

1.1.9 Reconstructive surgical revisions

1.1.10 Tissue/muscle reconstruction procedures (e.g. flaps), including, but not limited to, the following:

1.1.10.1 Deep inferior epigastric perforator (DIEP) flap

1.1.10.2 Latissimus dorsi (LD) myocutaneous flap

1.1.10.3 Ruben's flap (deep circumflex iliac artery flap)

1.1.10.4 Superficial inferior epigastric perforator/artery (SIEP/SIEA) flap

1.1.10.5 Superior or inferior gluteal free flap

1.1.10.6 Transverse rectus abdominus myocutaneous (TRAM) flap

1.1.10.7 Transverse upper gracilis (TUG) flap

1.2 Breast reconstruction procedures performed on the nondiseased/unaffected breast after having a mastectomy/lumpectomy, in order to produce a symmetrical appearance do not require prior authorization and are considered medically necessary, including:

1.2.1 Areolar and nipple reconstruction

1.2.2 Areolar and nipple tattooing

1.2.3 Augmentation with implantation of FDA-approved internal breast prosthesis

1.2.4 Autologous fat transplant (e.g. lipoinjection, lipofilling, lipomodeling)

1.2.5 Breast implant removal and subsequent reimplantation when performed to produce a symmetrical appearance

1.2.6 Breast reduction by mammoplasty or mastopexy

1.2.7 Capsulectomy

1.2.8 Capsulotomy

1.2.9 Reconstructive surgery revisions to produce a symmetrical appearance

2.0 Breast reconstruction done for certain congenital abnormalities **do not** require a prior authorization and are considered medically necessary for conditions including:

2.1 Poland syndrome

2.2 Tubular, severely constricted, or congenital absence of the breast

3.0 Inverted Nipples/Nipple Reconstruction

3.1 Plastic surgery for correction of asymptomatic inverted nipples is considered not medically necessary and therefore is not covered.

3.2 Surgery to correct inverted nipples that cause chronic mastitis **requires** prior authorization through the Health Services Division and may be considered medically appropriate.

4.0 Suction lipectomy or ultrasonically-assisted suction lipectomy (liposuction) for correction of surgically-induced donor site asymmetry (e.g. trunk or extremity) that results from one or more flap breast reconstruction procedure(s) are considered not medically necessary.

5.0 The following breast reconstruction procedures and treatments are considered experimental and investigational and therefore are not medically necessary.

5.1 Autologous fat transplant with the use of adipose-derived stem cells

5.2 Vascularized lymph node transfer (VLNTx)

5.3 Xenograft cartilage grafting.

6.0 The following breast procedures are considered not medically necessary and therefore not covered when related to cosmetic breast procedures:

6.1 Insertion or replacement of an existing breast implant or implant material if the breast implant is or was performed as a cosmetic procedure

6.2 Breast reduction surgery that is determined to be a cosmetic or not medically necessary procedure.

6.3 Breast prosthetics or replacement following a cosmetic breast augmentation.

6.4 Mastopexy

	Committee/Source	Date(s)
Document created:	Medical Policy Committee/Health Services Division	February 20, 2019
Revised:	Medical Policy Committee/Health Services Division	February 19, 2020
	Medical Policy Committee/Health Services Division	February 19, 2020
Reviewed:	Medical Policy Committee/Health Services Division	February 17, 2021

Published/Effective: 03/01/2021