Post-Mastectomy Surgery and Services

Clinical Coverage Criteria

Overview

The Women's Health and Cancer Rights Act (WHCRA), enacted October 21, 1998, amended the Public Health Service Act (PHS Act) and the Employee Retirement Income Security Act of 1974 (ERISA). The WHCRA is administered by the Department of Health and Human Services and the Department of Labor.

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, Fallon Health provides coverage 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; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Coverage cannot be denied based upon the period of time between the mastectomy and the request for reconstructive surgery; because the member had the mastectomy prior to joining a plan; or because the mastectomy was not as a result of cancer (despite the title, nothing in the WHCRA limits the benefit to cancer patients).

The WHCRA does not prohibit health plans from imposing copayments, deductibles, or coinsurance requirements on health benefits in connection with a mastectomy and reconstruction as long as such requirements are consistent with those established for other benefits under the plan. Please consult the individual plan benefits for specific information.

Policy

Fallon Health requires Prior Authorization for most Post-Mastectomy Services. The below is a general overview of the different types of services covered. Please consult Fallon Health's Cosmetic Surgery Service Policy for specific criteria for these procedures. A cancer diagnosis is required for coverage under this policy.

Post-Mastectomy Reconstruction requires Prior Authorization:

- All stages of reconstruction of the breast on which the mastectomy was performed, including but not limited to:
    - Prosthetic implant reconstruction with tissue expander
    - Nipple/areolar reconstruction and/or tattooing
- Surgery of the contralateral breast to achieve a symmetrical appearance, including but not limited to:
    - Mastopexy
    - Reduction mammoplasty

    - Augmentation mammoplasty, with or without prosthetic implant
- Revision of a previously reconstructed breast or revision of a procedure performed on the contralateral breast for medically necessary indications, including but not limited to removal and replacement of prosthetic implants, or to achieve symmetry.
- Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas.

Breast Prostheses:
Prior authorization may be required for certain types of prosthesis. One prefabricated external breast prosthesis is covered for the useful lifetime of the prosthesis (two breast prostheses, one per side, are covered for women who have had bilateral mastectomies). The useful lifetime expectancy for a silicone breast prosthesis (HCPCS code L8030) is two years. For fabric, foam, or fiber filled breast prostheses (HCPCS code L8020), the useful lifetime expectancy is 6 months. Replacement sooner than the useful lifetime is not covered, except when the prosthesis is lost or irreparably damaged (this does not include ordinary wear and tear), or the plan member's condition changes such that the current equipment no longer meets the plan member's needs. A breast prosthesis may be attached to the chest wall with an adhesive skin support (HCPCS code A4280), or worn in a mastectomy bra (HCPCS code L8000), which is specially designed with a pocket to hold the prosthesis in place.

Mastectomy Bras:
Prior Authorization is not required for these specific codes. Fallon Health covers two mastectomy bras (HCPCS code L8000, L8001, or L8002) per calendar year. A post-mastectomy camisole-type undergarment (HCPCS code L8015), is covered for use during the post-operative period, or as an alternative to a breast prosthesis and mastectomy bra. The garment includes two poly-fill breast forms. Replacement breast forms are sold separately. Fallon Health covers two post-mastectomy camisole garments per calendar year.

Exclusions

Please note some of the below items may be covered for specific products, please consult the plan benefits for the product for coverage and authorization requirements.

- The additional features of a custom fabricated breast prosthesis (HCPCS code L8035) are not medically necessary. (This is covered for Medicare Products)
- Nipple prosthesis, silicone or equal, with integral adhesive (HCPCS L8032).

Codes

The following table is a range of codes currently available and may not be all inclusive.

Code type	Code	Description
CPT	19316	Mastopexy
	19318	Reduction mammaplasty
	19324	Mammaplasty, augmentation; without prosthetic implant
	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/areola reconstruction
	19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
	19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
	19364	Breast reconstruction with free flap
	19366	Breast reconstruction with other technique
	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
	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
	19396	Preparation of moulage for custom breast implant
HCPCS	A4280	Adhesive skin support attachment for use with external breast prosthesis, each
	L8000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type.
	L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type.
	L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type
	L8015	External breast prosthesis garment, with mastectomy form, post-mastectomy.
	L8020	Breast prosthesis, mastectomy form
	L8030	Breast prosthesis, silicone or equal, without integral adhesive
	L8031	Breast prosthesis, silicone or equal, with integral adhesive
	L8039	Breast prosthesis, not otherwise specified

References

1. United States Code, Title 29, Chapter 18, Subchapter 1, Subtitle B, Part 7, Subpart B, § 1185b. Required coverage for reconstructive surgery following mastectomies.
2. Centers for Medicare & Medicaid Services, Medicare Coverage Database. Noridian Healthcare Solutions, LLC. LCD for External Breast Prostheses (L33317). Last Revision Effective Date January 1, 2019

Policy History

Origination date: 01/1993

Approval(s): Utilization Management Committee: 05/2000, 06/2003
Technology Assessment Subcommittee: 07/05/2005
Benefits Committee: 01/1993, 01/1995, 03/2002
Benefit Oversight Committee: 01/14/2009, 08/11/2010
Technology Assessment Committee: 01/2002, 10/04/2005, 09/24/2014 (updated template and exclusions) 09/23/2015 (removed autologous fat graft exclusion) 09/15/2016 (updated references), 09/27/2017 (updated references, clarified a cancer diagnosis is required for coverage), 08/22/2018 (annual review, no updates), 09/10/2019 (updated references)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.