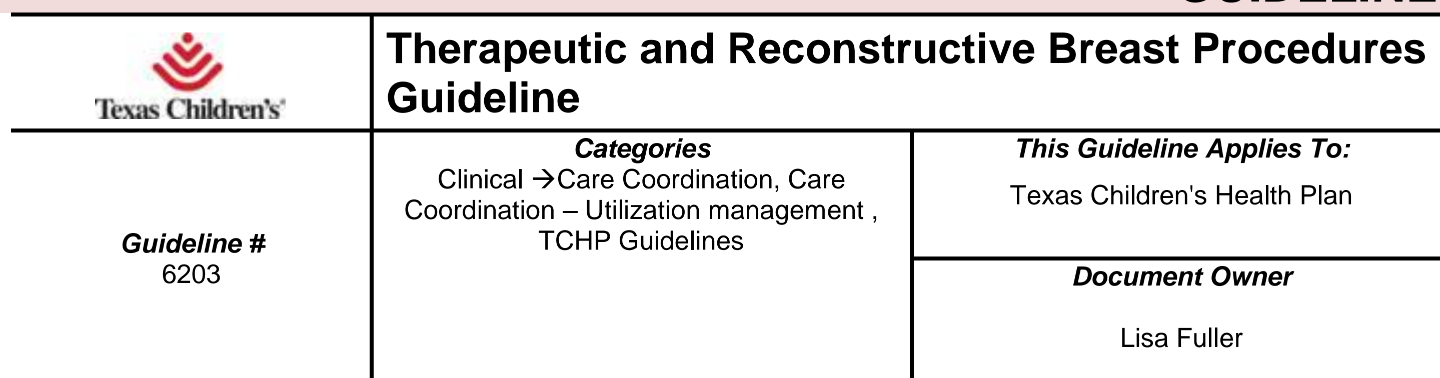

GUIDELINE

Texas Children's	**Therapeutic and Reconstructive Breast Procedures Guideline**	
Guideline # 6203	***Categories*** Clinical →Care Coordination, Care Coordination – Utilization management , TCHP Guidelines	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Lisa Fuller

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all Surgical Breast Procedures, including prosthesis**.**

DEFINITIONS:

Reconstructive Breast Procedures rebuild the normal contour of the affected or the contralateral unaffected breast to produce a more normal appearance. They can include any or all of the following:

- Reconstructive surgery and implant insertion;
- Procedures where muscle tissue is transposed from another site;
- Reconstruction of the contralateral breast to achieve symmetry with reduction mammoplasty, augmentation mammoplasty with implants, or mastopexy;
- Revision or removal of pre-existing breast implants placed for cosmetic purposes.

PRIOR AUTHORIZATION GUIDELINES

1. All requests for prior authorization for Therapeutic and Reconstructive Breast Procedures are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

2. To request prior authorization for Surgical Breast Procedures or breast prostheses, the requesting provider must submit clinical documentation of medical necessity for the requested date of service that includes the following: a complete history and physical examination that documents the chief complaint, diagnosis and history of the medical condition(s) requiring surgical treatment; weight, height of member, relevant past medical and past surgical history, family history and the proposed surgical procedure and treatment plan.

3. Mastectomy for pubertal gynecomastia is a benefit with prior authorization for males who are age 20 years and younger. The following documentation must be submitted with the prior authorization request:

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3.1 Clinical notes that include a complete medical and family history and treatment plan, including planned surgical procedure and timelines for surgery.
3.2 A thorough physical examination which includes identification of the affected breast or breasts that require mastectomy.

4. Members requesting a reduction mammoplasty, requesting physician should provide documentation of a mammogram that is negative for cancer within the past year
   4.1 Identify the location or facility where the services will be provided if applicable

5. Members 17 years of age and younger
   5.1 Prior authorization is required.

Medical Necessity for Therapeutic and Reconstructive Breast Procedures:

6. **Mastectomy or partial mastectomy (e.g. lumpectomy, tylectomy, quadrantectomy and segmentectomy)** are considered medically necessary when indicated to remove a breast or portion of a breast for any of the following:

6.1 Developmental abnormality
6.2 Congenital defect
6.3 Trauma or injury to the chest wall
6.4 Primary or secondary malignancy of the breast
6.5 Carcinoma in situ of the breast
6.6 Prophylactic for members who are at moderate to high risk for the development of breast cancer as evidenced by:
6.6.1 Current or previous diagnosis of breast cancer
6.6.2 Family history of breast cancer in mother, sister, or daughter, especially before the age of 50
6.6.3 Presence of any of the following genetic mutations:
6.6.3.1 Breast cancer gene 1 (BRCA1)
6.6.3.2 Breast cancer gene 2 (BRCA2)
6.6.3.3 Tumor protein 53 (TP 53)
6.6.3.4 Phosphatase and tensin homolog (PTEN)
6.6.3.5 Lobular carcinoma in situ (LCIS)
6.6.3.6 Radiation therapy to the chest before a client reaches 30 years of age
6.6.3.7 Recommendation by current National Comprehensive Cancer Network (NCCN) guidelines

7. Mastectomy for **pubertal gynecomastia** is considered medically necessary when the clinical documentation submitted shows that member meets all the following criteria:

7.1 Gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.

7.2 Member is a male 20 years of age younger or has evidence that puberty is near completion, as indicated by 95 percent of adult height based on bone age and Tanner stage V has been achieved

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7.3 Evidence that the client has been off gynecomastia inducing drugs or other substances for a minimum of one year when this has been identified as the cause of the gynecomastia.

7.4 Evidence of resolution as supported by appropriate test results and treatment for hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas, and hypogonadism, for a minimum of one year when identified as the cause of the gynecomastia.

7.5 Evidence of a psychiatric assessment performed by a psychiatrist or psychologist

7.6 History and treatment plan including planned surgical procedure and timeline

8. **Reconstructive breast procedures** may be performed in a single stage or several stages. Breast reconstruction is considered medically necessary in the following situation:

8.1 Breast surgery of one or both breasts following the mastectomy of one or both breasts.

8.2 Breast surgery to alter the contour of the breast when there are significant abnormalities related to trauma, congenital defects, infection or other non-malignant disease. A specific example of this is Poland's syndrome which may be diagnosed when all of the following are present:

8.1.1 Congenital absence or hypoplasia of pectoralis major and minor muscles; and

8.1.2 Breast hypoplasia; and

8.1.3 Congenital partial absence of the upper costal cartilage.

8.2 Removal of an implant (any type) with or without reimplantation when an implant, originally placed in an individual with a history of mastectomy, lumpectomy or treatment of breast cancer develops a visible distortion (Baker Class III contracture).

8.3 Removal of a saline-filled or "Alternative" implant with or without reimplantation when originally placed in an individual with a history of mastectomy, lumpectomy or treatment of breast cancer if it ruptures, becomes infected or when there is an inflammatory reaction to the implant.

8.4 Surgery on the contralateral breast to produce a symmetrical appearance after removal of an implant and reimplantation when the implant was originally placed in an individual with a history of mastectomy, lumpectomy or treatment of breast cancer.

9. Documentation that supports medical necessity for breast reconstruction, including tattooing, must include the following:

9.1 diagnosis causing the need for breast reconstruction

9.2 date of previous mastectomy, when appropriate

9.3 date of any previous breast reconstruction procedures, when appropriate

9.4 proposed treatment plan which includes planned surgical procedures

9.5 timeline for completion

9.6 identification of the complication, when appropriate

10. **Reduction Mammoplasty** is considered medically necessary when current applicable Interqual criteria are met, unless a member meets **BOTH** of the following criteria in 10.1 and 10.2:

10.1 Presence of one or more of the following that has persisted for at least one year:

10.1.2 Cervical or thoracic pain syndrome (upper back and shoulder pain); or

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10.1.3 Submammary intertrigo that is refractory to conventional medications and measures used to treat intertrigo, or shoulder grooving with or without ulceration, unresponsive to conventional therapy; or

10.1.4 Thoracic outlet syndrome (to include ulnar paresthesias from breast size) that has not responded to at least three (3) months of adequate conservative treatment.

10.2 The preoperative evaluation by the surgeon concludes that an appropriate amount of breast tissue, per breast, will be removed and based upon the body surface area of the patient and that there is a reasonable prognosis of symptomatic relief. The request for surgery must include:

10.2.1 individual's height and weight

10.2.2 the size and shape of the breast(s) causing symptoms

10.2.3 the anticipated amount of breast tissue to be removed

10.2.4 the minimum weight of tissue expected to be removed from a single breast with consideration to height and weight is as follows:

10.2.4.1 Any member who is anticipated to have at least 1 kg of breast tissue removed from each breast qualifies as having an expected appropriate amount of tissue to be removed.

Height /ft	**Weight /lbs**	**Average grams of tissue per breast to be removed**
Less than 5'	Less than 140lbs	300 grams per breast
5' - 5'.4"	Up to 180	350 grams per breast
5'.4"- 5'.7"	Up to 220	400 grams per breast
5'.7"- up	211lbs and up	500 grams per breast

9. External breast prostheses are considered medically necessary for any female member with a history of a medically necessary mastectomy.

10. Requests that do not meet the criteria established by this guideline will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

11. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

12. The following list of applicable procedure codes is provided here for reference purposes only and may not be all inclusive. The most up to date list can be found on the Texas Children's Health Plan website in the Provider section under Prior Authorization Reference Information.

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Therapeutic and Reconstructive Breast Procedures, Code and Description

11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander(s) without insertion of implant
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
19325	Breast augmentation with implant
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)

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19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
S2068	Breast reconstruction with deep inferior epigastric perforat
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19499	Unlisted procedure, breast
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
L8010	Breast prosthesis, mastectomy sleeve
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy

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L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8031	Breast prosthesis, silicone or equal, with integral adhesive
L8032	Nipple prosthesis, reusable, any type, each
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8039	Breast prosthesis, not otherwise specified
19300	Mastectomy for gynecomastia
19316	Mastopexy
19318	Breast reduction
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19396	Preparation of moulage for custom breast implant
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of

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	skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

REFERENCES:

Government Agency, Medical Society, and Other Publications:

Texas Medicaid Provider Procedure Manual, Accessed January 2, 2024 TMPPM.book (tmhp.com)

Peer Reviewed Publications:

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Chung KC. Discussion: Managing late periprosthetic fluid collections (seroma) in patients with breast implants: a consensus panel recommendation and review of the literature. Plast Reconstr Surg. 2011; 128(1):13-16.

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The Women's Health and Cancer Rights Act (WHCRA), §713; October 21, 1998. Available at: http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/WHCRA_Statute.pdf. .

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