AMERICAN SOCIETY OF PLASTIC SURGEONS

ASPS Recommended Insurance Coverage Criteria for Third-Party Payers

Breast Reconstruction Following Diagnosis and Treatment for Breast Cancer

BACKGROUND

For women, the function of the breast, aside from the brief periods when it serves for lactation, is an organ of female sexual identity. The female breast is a major component of a woman's self image and is important to her psychological sense of femininity and sexuality. Individuals with abnormal breast structure(s) often suffer from a severe negative impact on their self esteem, which may adversely affect their sense of well-being.

Breast cancer is the second most frequently occurring cancer in the United States. Breast reconstruction after cancer treatment is the most common reason patients seek breast reconstruction surgery. Many women find that surgical reconstruction of the missing breast is an essential component in their recovery from cancer.

DEFINITION: COSMETIC AND RECONSTRUCTIVE SURGERY

For reference, the following definition of cosmetic and reconstructive surgery was adopted by the American Medical Association, June 1989:

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

POLICY

Breast reconstruction of the affected breast, as well as surgery on the contralateral breast to achieve symmetry, is considered reconstructive surgery and in accordance with the Women's Health and Cancer Rights Act must be a covered benefit and reimbursed by third-party payers.

Legislation: Women's Health and Cancer Rights Act of 1998

In October 1998, federal legislation was signed into law requiring group health plans and health issuers that provide medical and surgical benefits with respect to mastectomy, to cover the cost of reconstructive breast surgery for women who have undergone a mastectomy. The law states:

- *The attending physician and patient are to be consulted in determining the appropriate type of surgery.*
- *Coverage must include all stages of reconstruction of the diseased breast, procedures to restore and achieve symmetry on the opposite breast and the cost of prostheses and complications of mastectomy, including lymphedema.*

*Group health plans and health insurance issuers offering group health coverage **may not**:*

- *Deny a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of the statute.*
- *Penalize, reduce, or limit the reimbursement of an attending provider.*
- *Provide incentives to attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.*

The statute extends the requirement to self-insured plans under ERISA federal law, and preempts state laws that do not provide at least the same level of coverage. Violations of this federal legislation may be reported to the Department of Labor at 202-219-8776.

DIAGNOSIS CODING

Diagnosis	ICD-9
A. Malignant neoplasm of female breast	174.0 – 174.9
B. Malignant neoplasm of male breast	175.0 & 175.9
C. Personal history of malignant neoplasm of breast	V10.3
D. Acquired absence of breast	V45.71
For surgery of the opposite breast	
A. Macromastia	611.1
B. Breast Asymmetry	611.8
C. Ptosis	611.8

See ASPS® Recommended Insurance Coverage Criteria for Prophylactic Mastectomy for diagnosis code V16.3, family history of malignant neoplasm of breast.

SURGICAL TREATMENT OF BREAST CANCER

Mastectomies can be segmental, partial, complete or total (modified radical or radical with muscle resection). Mastectomies can be indicated for malignant, pre-malignant or in rare situations, for benign disease processes.

Lumpectomy, also referred to as a tylectomy, is the surgical excision of a cancerous lump along with a margin of normal breast tissue. Twenty to 30% of patients undergoing a lumpectomy will be left with breast deformities that vary greatly depending on the type of resection, radiation therapy, breast size and shape, and tumor location.

Reconstruction Following the Treatment of Breast Cancer

A variety of reconstruction techniques are available to accommodate a wide range of breast deformities resulting from mastectomy or lumpectomy. The technique(s) selected are dependent on the nature of the defect, the patient's individual circumstances and the surgeon's judgment. When developing the surgical plan, the surgeon must correct underlying deficiencies, as well as take into consideration the goal of achieving bilateral symmetry.

Depending on the individual patient circumstances, surgery on the contralateral breast may be necessary to achieve symmetry. Surgical procedures on the opposite breast may include reduction mammaplasty and mastopexy with or without augmentation.

POSSIBLE CPT CODING

A. Mastopexy	19316
B. Reduction mammaplasty	19318
C. Mammaplasty, augmentation; without prosthetic implant	19324
D. With prosthetic implant	19325
E. Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	19340
F. Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	19342
G. Nipple/areolar reconstruction	19350
H. Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	19357
I. Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant	19361
J. Breast reconstruction with free flap	19364
K. Breast reconstruction with other technique	19366
L. Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	19367
M. With microvascular anastomosis (supercharging)	19368
N. Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site.	19369
O. Open periprosthetic capsulotomy, breast	19370
P. Periprosthetic capsulectomy, breast	19371
Q. Revision of reconstructed breast	19380
R. Preparation of moulage for custom breast implant	19396
S. Unlisted procedure, breast	19499

REFERENCES

1. http//seers.cancer.gov. Accessed 3/16/04.
2. www.plasticsurgery.org. Procedural Statistics. Accessed 3/16/04.
3. www.cancer.org. Accessed 3/16/04.
4. Feuer, EJ. Reports: The lifetime risk of developing breast cancer. http//seers.cancer.gov. Accessed 3/16/04.
5. Greene, MH. Genetics of breast cancer. *Mayo Clinic Proc.* 72: 54-65, 1997.
6. Chang, DW., Kroll, SS., Dackiw, A., et al. Reconstructive management of the contralateral breast in patients who previously underwent unilateral breast reconstruction. *Plast. Reconstr. Surg.* 108: 352, 2001.
7. Kunkel, EJ. and Chen, EI. Psychiatric aspects of women with breast cancer. *Psychiatr. Clin. North Am.* 26: 713, 2003.
8. www.dol.gov/ebsa. Accessed 3/16/04.
9. Thompson, TA., Pusic, A., Kerrigan, C., et al. Surgeon's perspective on surgical options for early stage breast cancer. *Plast. Reconstr. Surg.* 105: 910, 2000.
10. Rutqvist, LE., Rose, C., and Cavillan-Stahl, E. A systematic overview of radiation effects in breast cancer. *Acta Oncologica.* 42: 532, 2003.
11. Malata, CM., McIntosh, SA., and Purushotham, AD. Immediate breast reconstruction after mastectomy for cancer. *Br. J. Surg.* 87: 1455, 2000.
12. Sakorafas, GH. Breast cancer surgery. *Acta Oncologica.* 40: 5, 2001.
13. Grotting, JC., Beckenstein, MS. and Arkoulakis, NS. The art and science of autologous breast reconstruction. *Breast J.* 9: 350, 2003.
14. Stanec, S., Zic, R., Budi, S. and Syanec, Z. Deep inferior epigastric perforator flap. A modification that simplifies elevation. *Ann. Plast. Surg.* 50: 120, 2003.
15. Elliott, LF. and Hartrampf, CR., Jr. The Ruben flap. The deep circumflex iliac artery flap. *Clin. Plast. Surg.* 25: 283, 1998.

AMERICAN SOCIETY OF PLASTIC SURGEONS

Approved by the ASPS® Executive Committee: September 2004.