KAISER PERMANENTE® Northwest Region Utilization Review

UR 20.6 Breast Reconstruction Surgery Medical Necessity Criteria

Department: Surgery	Number: UR 20.6
Section: Plastic Surgery	Effective: 9/14
Applies to: KPNW Region	Last Reviewed: 2/24, 3/25, 3/17/26
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MEDICAL NECESSITY CRITERIA AND OTHER REQUIREMENTS FOR BREAST RECONSTRUCTION SURGERY

Medical necessity criteria are applied only after member eligibility and benefit coverage is determined. Questions concerning member eligibility and benefit coverage need to be directed to Membership Services.

DEFINITIONS

See the Evidence of Coverage (EOC) as definitions of *Cosmetic Services* may vary within the Exclusions section of the EOC documents (this exclusion does not apply to 'Reconstructive Surgical Services' or services that are medically necessary).

POLICY AND CRITERIA

Coverage guidance: Breast reconstruction services may be excluded from coverage. Check for exclusions or limitations.

Source	Policy
For Medicare Members	
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	NCD 140.2 "Breast Reconstruction Following Mastectomy"
Local Coverage Determinations (LCD)	L35163 "Plastic Surgery"
Local Coverage Article	None
Kaiser Permanente Medical Policy for Medicare Members	UR 20.6 does not apply. For Medicare lines of business, apply the criteria in the NCD and/or LCD.
For Medicaid Members	
OR Medicaid	UR 20.6 does not apply. Check Linefinder.
WA Medicaid	UR 20.6 does not apply.
Commercial and Self-Funded Members	
OR Commercial	UR 20.6 applies
WA Commercial	UR 20.6 applies
Self-Funded Plans	UR 20.6 applies

Patients will be eligible for breast reconstructive surgery under these criteria only 1) after medically necessary mastectomy or lumpectomy related to breast cancer or 2) to correct significant disfigurement resulting from an injury or from medically necessary surgery.

- Reconstructive surgery of the affected side may include any or all of the following:
    - Tissue reconstruction (e.g., flaps)
    - Use of tissue expanders
    - Implantation of FDA-approved internal breast prosthesis. Augmentation may be appropriate only when one of the following conditions is met:
        - Patient has undergone lumpectomy but NOT radiation therapy; OR
        - Patient has undergone mastectomy, with or without radiation therapy
    - Areolar and nipple reconstruction
    - Areolar and nipple tattooing
    - Autologous fat grafting
    - Liposuction
    - Mastopexy or reduction (e.g. oncoplastic reduction)
    - Capsule revision (capsulotomy, capsulectomy, capsulorrhaphy)
    - Dermal rearrangement (i.e. “Goldilocks” flaps)

- Reconstructive procedures may be performed on the contralateral (unaffected) side to restore the appearance of the breasts to the level of symmetry present prior to mastectomy or lumpectomy ONLY when mastectomy or lumpectomy has produced significant asymmetry.
    - The patient qualifies as having significant asymmetry when the following criteria are met:
        - There is an absence of breast tissue unilaterally where there is no ability to maintain a normal breast shape using non-surgical methods; AND
        - At least 250 g of tissue were removed OR there is a difference of at least 1 cup size.
    - Reconstructive surgery of the contralateral (unaffected) side may include any of the following when the above criteria are met:
        - Breast reduction by mammoplasty or mastopexy
        - Augmentation mammoplasty
        - Areolar and nipple reconstruction
        - Areolar and nipple tattooing
        - Capsulotomy
        - Capsulectomy
        - Breast implant removal and subsequent re-implantation when original implant was in the unaffected breast prior to disease in the affected breast
        - Liposuction
        - Autologous fat grafting

- Reconstructive procedures are considered medically necessary when performed either at the time of mastectomy (immediate reconstruction) or in a staged manner following mastectomy (delayed reconstruction). Contraindications to immediate reconstruction are:
        - Severe obesity (BMI >40)
        - Uncontrolled diabetes (HbA1c >8.0)
        - Inflammatory breast cancer

- Members who decline or are non-compliant with standard of care cancer treatment
- Active or recent use of tobacco and/or tobacco products* (members with a history of tobacco products* use must have a documented "quit" date >6 months prior to referral for consultation OR a negative urine anabasine test (level below 3 ng/dl) within the last 30 days if quit ≤6 months prior to referral for consultation.
  *tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff))

- Reconstructive surgical revisions may be performed as deemed necessary by a physician board-certified in plastic surgery.
  - Revisions will not be covered when performed to correct changes in form or symmetry due to natural processes, such as aging or changes in weight.
  - Once the initial sequence of tattoo sessions has been completed, further touch-ups will be considered cosmetic.

CONTRAINDICATIONS (TO BE DETERMINED BY THE SURGEON)

1. Nicotine use, including tobacco products* and nicotine replacement therapy (NRT) products** within the 30 days prior to surgery.

*tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff)
**NRT products: nicotine gum, lozenges, sublingual tablets, transdermal patch, nasal spray, inhaler.

2. Uncontrolled diabetes as indicated by a HbA1c of 8.0 or higher. Members with a HbA1c in the 7-8 range may be assessed for relative contraindications on a case-by-case basis.
3. Obesity is also a risk factor for poor surgical outcome. Members who are obese but otherwise meet the above medical necessity criteria will be assessed on a case-by-case basis.
4. Any other surgical contraindications will be determined by the surgeon.

RATIONALE

EVIDENCE BASIS

A 2021 Agency for Healthcare Research and Quality (AHRQ) systematic review of surgical breast reconstruction options after mastectomy for breast cancer compared implant-based reconstruction (IBR) vs. autologous reconstruction (AR), assessed evidence about the timing of IBR and AR in relation to chemotherapy and radiation therapy, compared implant materials for IBR, compared anatomic planes of implant placement during IBR, evaluated the used of acellular dermal matrices (ADMs) during IBR, and compared flap types for AR.[1] The overall conclusions of this review are as follows:

> "Our analysis of all surgical choices examined as KQs in this review finds no clear winners when all outcomes are considered. We encourage clinicians to inform patients about the limitations of existing research and to help patients make decisions regarding options for breast reconstruction based on their values and preferences, together with the clinician's expertise and experience. Research is needed to address various questions related to breast reconstruction, particularly the timing of IBR and AR in relation to chemotherapy and radiation therapy, and the choices of implant materials, anatomic planes of implant placement during IBR, and flaps used for AR. Future studies should either randomize patients or adequately account for important confounders and evaluate key outcomes, especially those in the existing core outcome set for breast reconstruction after mastectomy."[1]

Tobacco Use:

A 2018 systematic review of the effect of smoking on post-operative outcomes in patients who had common elective procedures in plastic surgery reports that tobacco use was associated with a significant increase in the total number of post-operative complications following breast reconstruction.[2] These complications include donor site complications, infection, and fat necrosis, all of which were significantly more common among smokers compared to non-smokers.[2] A 2015 systematic review of the association between smoking status and outcomes of plastic surgery reports significantly increased odds of surgical site infections, delayed wound healing, and cutaneous necrosis among patients who were smokers compared to non-smokers.[3]

REFERENCES

1. Saldanha IJ, Cao W, Broyles JM, Adam GP, Bhuma MR, Mehta S, Dominici LS, Pusic AL, Balk EM. Breast Reconstruction After Mastectomy: A Systematic Review and Meta-Analysis. Comparative Effectiveness Review No. 245. (Prepared by the Brown Evidence-based Practice Center under Contract No. 75Q80120D00001.) AHRQ Publication No. 21-EHC027. Rockville, MD: Agency for Healthcare Research and Quality; July 2021. DOI: 10.23970/AHRQEPCCER245.
2. Theocharidis V, Katsaros I, Sgouromallis E, et al. Current evidence on the role of smoking in plastic surgery elective procedures: A systematic review and meta-analysis. *J Plast Reconstr Aesthet Surg*. May 2018;71(5):624-636. doi:10.1016/j.bjps.2018.01.011
3. Pluvy I, Panouillères M, Garrido I, et al. Smoking and plastic surgery, part II. Clinical implications: a systematic review with meta-analysis. *Ann Chir Plast Esthet*. Feb 2015;60(1):e15-49. doi:10.1016/j.anplas.2014.09.011
4. WHCRA (Women's Health and Cancer Rights Act)
5. ORS 743A.110 Mastectomy-related Services
6. Oregon House Bill 3616 amending ORS 743A.110- defines "mastectomy" for purposes of statute requiring health benefit plan coverage
7. Xu, Z., Norwich-Cavanaugh, A., Hsia, HC (2019), Can Nicotine Replacement Decrease Complications in Plastic Surgery? *Annals of Plastic Surgery*. 83: S55-S58.