Breast Procedures

Humana

Medicaid Medical Coverage Policy

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State(s): OH

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Scope

This policy applies to all physical and behavioral health prior authorization requests received by Humana Healthy Horizons™ in Ohio.

Policy

Humana Healthy Horizons™ in Ohio uses established criteria guidelines to make medical necessity decisions and follows the below procedure. Decisions are made on a case-by-case basis, utilizing the information provided about the member's health status and an assessment of the local delivery system. Emergent services do not require a referral or preauthorization.

The Plan covers all benefits and services required in Ohio Administrative Code (OAC) chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.

When the plan receives a request for a primary code that requires prior authorization and the primary code is denied for lack of medical necessity, any related secondary codes submitted on the authorization request

will be denied based on lack of medical necessity. When a primary code is approved, related secondary codes requiring prior authorization will be reviewed individually for medically necessity determinations.

Please see Ohio Medicaid Prior Authorization and Notification List for a list of CPT and HCPCS codes that require prior authorization.

Humana Healthy Horizons™ in Ohio will review requested non-MCO covered codes and services as required for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for medical necessity to ensure children and adolescents receive appropriate and preventative, dental, mental health, developmental and specialty services.

Humana Healthy Horizons™ in Ohio does not cover services, items or devices that have not been approved by the Food and Drug Administration (FDA). Other factors affecting reimbursement supersede this policy. These factors include but are not limited to Federal and/or State statutes and regulations, the State Plan, the MCE Manual, physician or other provider contracts, the beneficiaries' benefit coverage documents, and/or other reimbursement, medical or drug policies.

Providers may submit authorization request(s) through the provider portal. A provider may request an urgent prior authorization in situations where the provider considers a delay in providing services, supplies or prescription drugs requiring prior authorization to be detrimental to the health of the member. The absence of authorization and/or notification prior to the date of a service could result in financial penalties for the practice and reduced benefits for the member, based on the healthcare provider's contract and the member's Certificate of Coverage. Services or medications provided without preauthorization may be subject to retrospective medical necessity review. We recommend individual practitioners making specific requests for services or medications verify benefits and preauthorization requirements with Humana prior to providing services.

Medical necessity documentation and rationale must be submitted with the prior authorization request. Providers may access physical and behavioral clinical coverage policies and medical necessity criteria at the below links.

Physical Health:
www.humana.com/provider/medical-resources/ohio-medicaid/physical-health-clinical-coverage-policies

Behavioral Health:
www.humana.com/provider/medical-resources/ohio-medicaid/behavioral-health-clinical-coverage-policies

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, 7AM to 8PM EST.

Providers may request a copy of the medical necessity criteria by calling provider services at 877-856-5707 (TTY:711), Monday-Friday, 7AM to 8PM EST or emailing the request to ODMCDUM@humana.com.

Procedures

1. The Plan uses the following hierarchy of guidelines to review for medical necessity:
   - 1.1 Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
   - 1.2 Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines).
   - 1.3 Humana Healthy Horizons™ in Ohio clinical policies
   - 1.4 In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes;
     - 1.4.1 Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
     - 1.4.2 Professional standards for safety and effectiveness recognized in the US for diagnosis, care, or treatment;
     - 1.4.3 Medical association publications;
     - 1.4.4 Government-funded or independent entities that assess and report on clinical care; Decision and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
     - 1.4.5 Published expert opinions;
     - 1.4.6 Opinion of health professionals in the area of specialty involved;
     - 1.4.7 Opinion of attending provider;
   - 1.5 Dental: DentaQuest coverage guidelines and policies
     Dental Coverage - Humana Healthy Horizons in Ohio | Humana
   - 1.6 Vision: EyeMed coverage guidelines and policies
     Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

Description

Breast reconstruction surgery rebuilds a breast's shape following a mastectomy or trauma and may be performed immediately, be delayed or be completed in stages. The surgeon forms a breast mound by using autologous tissue taken from other areas of an individual's body (abdomen, back, buttocks, thighs), placing an artificial implant, or using a tissue expander if necessary, depending on the final desired breast size.

The type of reconstruction recommended (autologous tissue or implants) depends on an individual's age, body composition, general health status, method of planned cancer treatment or other reason for reconstruction. Breast reconstruction may require multiple surgeries, such as nipple and areola reconstruction and tattoo pigmentation, revision surgery involving the breast and/or donor site or surgery

on the opposite breast to correct asymmetry. **Mastopexy** or a breast lift, breast reduction or breast augmentation may be recommended for the opposite breast to improve symmetry of the size, shape and position of both breasts.

Breast implants are silicone sacs filled with saline (salt water) or silicone gel. The development of scar tissue around a breast implant may necessitate a capsulotomy (surgical opening and release of scar tissue) or capsulectomy (surgical removal of the entire capsule containing the breast implant surrounded by abnormally thick, hardened tissue).

Reduction mammaplasty (also spelled mammoplasty), or breast reduction surgery, reduces the volume and weight of the breasts by removing excess glandular tissue, skin and subcutaneous fat. The goals of the surgery are to relieve symptoms caused by heavy breasts, to create a natural, balanced appearance with normal location of the nipple and areola, to maintain the capacity for lactation and allow for future breast exams/mammograms, with minimal scarring or decreased sensation. The traditional method of breast reduction requires an open incision around the areola extending downward to the crease beneath the breast. Excess breast tissue, fat and skin are removed, and placement of the nipple and areola are adjusted.

In a **liposuction-only reduction mammaplasty**, a small access incision is made in one of the following locations: axillary (under the arm), periareolar (around the nipple) or in the inframammary fold (under the breast). Anesthesia may be injected along with saline solution until the tissue is firm, and a suction cannula is used to extract fat from the breast.

Coverage Determination

Humana members may be eligible under the Plan for **breast reconstruction** when the following criteria are met:

An individual has had any of the following:

- A medically necessary mastectomy or lumpectomy (regardless of the date of the mastectomy or lumpectomy); **OR**
- A medically necessary prophylactic mastectomy; **OR**
- Trauma (within 12 months postinjury);

Surgical procedures include one or more of the following:

- Insertion of breast implants; **OR**
- Insertion of tissue expanders; **OR**
- Mastopexy (including prior to a nipple-sparing mastectomy); **OR**

- Nipple reconstruction; **OR**

- Reduction mammaplasty only if necessary to preserve nipple viability prior to a nipple-sparing mastectomy **(medical director review required)**

Correction of Breast Asymmetry

Humana members may be eligible under the Plan for breast reconstruction surgery to correct breast asymmetry following, or in conjunction with:

- A medically necessary lumpectomy that results in a deformity; **OR**

- A medically necessary mastectomy; **OR**

- Complications with or removal of breast implant(s) following a medically necessary mastectomy; **OR**

- Trauma (within 12 months postinjury)

Further modification related to achieving symmetry is subject to medical necessity and does not include procedures to fill the flap donor site.

Capsulectomy, Capsulotomy, Breast Implant Removal

Humana members may be eligible under the Plan for **capsulectomy, capsulotomy or breast implant removal** when the following criteria are met:

- Breast implants were placed in conjunction with a medically necessary (noncosmetic) surgery

  AND any of the following complications:

  - Capsular contracture (Baker grade III or IV); **OR**

  - Extrusion; **OR**

  - Breast implant rupture (confirmed by imaging such as magnetic resonance imaging [MRI] or ultrasound); **OR**

  - Implant infection refractory to medical management (eg, antibiotics) unless contraindicated;

    AND either:

    - Infection confirmed by microbiological analysis of peri-implant fluid aspirate; **OR**

    - Presence of symptoms such as fever, redness, elevated white blood cell (WBC) count

Breast Implant Associated Anaplastic Large Cell Lymphoma

Note: The following criteria apply **ONLY** to implant removal related to breast implant associated anaplastic large cell lymphoma BIA-ALCL.[4,15,16,23]

Humana members may be eligible under the Plan for **total capsulectomy with breast implant removal** for the following indications:

- Pathologic confirmation of breast implant associated anaplastic large cell lymphoma BIA-ALCL by cytological evaluation of seroma fluid or mass with Wright Giemsa stained smears and cell block immunohistochemistry/flow cytometry testing for cluster of differentiation (CD30) and anaplastic lymphoma kinase (ALK) markers[23]; **OR**

- Removal of Allergan BIOCELL textured breast implants and tissue expanders (due to increased risk of breast implant-associated anaplastic large cell lymphoma [BIA-ALCL]) [23]

Breast Implant Associated Squamous Cell Carcinoma

Humana members may be eligible under the Plan for **total capsulectomy with breast implant removal** for a confirmed diagnosis of breast implant-associated squamous cell carcinoma (BIA-SCC).

Humana members may be eligible under the Plan for **reinsertion of breast implants** following a medically necessary removal.

Reduction mammaplasty of the unaffected/contralateral breast

Humana members may be eligible under the Plan for **reduction mammaplasty of the unaffected/contralateral breast in conjunction with breast reconstruction** will be considered medically reasonable and necessary when performed to produce a symmetrical appearance following a medically necessary mastectomy or lumpectomy due to breast cancer.

Coverage Limitations

Humana members may **NOT** be eligible under the Plan for **breast reconstruction, capsulectomy, capsulotomy or breast implant removal or reduction mammaplasty procedures** for any indications other than those listed above.

Humana members may **NOT** be eligible under the Plan for **liposuction-only reduction mammaplasty**.
A review of the current medical literature shows that the **evidence is insufficient** to determine that this service is standard medical treatment. There is an absence of current, widely-used treatment guidelines or acceptable clinical literature examining benefit and long-term clinical outcomes establishing the value of this service in clinical management.

Humana members may **NOT** be eligible under the Plan for **correction of breast asymmetry** for any indications other than those listed above, including, but may not be limited to naturally occurring breast asymmetry or nipple reconstruction for inverted nipples. This is considered not medically necessary.

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
15877	Suction assisted lipectomy; trunk	
19316	Mastopexy	
19325	Breast augmentation with implant	
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	
19355	Correction of inverted nipples	
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)	
19396	Preparation of moulage for custom breast implant	
19499	Unlisted procedure, breast	
CPT® Category III Code(s)	**Description**	**Comments**
No code(s) identified		
HCPCS Code(s)	**Description**	**Comments**
C1789	Prosthesis, breast (implantable)	
L8600	Implantable breast prosthesis, silicone or equal	

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11. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Breast cancer. https://nccn.org. Published March 11, 2024.

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14. Ohio Administrative Code 5160-26-01 Managed care: definitions. Rule 5160-26-01 - Ohio Administrative Code | Ohio Laws.

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22. US Food & Drug Administration (FDA). Risks and complications of breast implants. https://fda.gov. Updated December 15, 2023.

23. US Food & Drug Administration (FDA). Safety Communication (ARCHIVED). The FDA requests Allergan voluntarily recall Natrell BIOCELL textured breast implants and tissue expanders from the market to protect patients. https://fda.gov. Published July 24, 2019. Updated June 1, 2020.

24. US Food & Drug Administration (FDA). Safety Communication. Update: reports of squamous cell carcinoma (SCC) in the capsule around breast implants. https://fda.gov. Updated March 22, 2023.

Appendix

Appendix A – Baker Grading Scale[22]

Grade	Breast appearance
Grade I	Breast is normally soft and appears natural
Grade II	Breast is firm but appears normal
Grade III	Breast is firm and appears abnormal
Grade IV	Breast is hard, painful and appears abnormal

Definitions

1. Adverse Benefit Determination – As defined in OAC rule 5160-26-01, is a managed care entity's (MCEs):
   1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
   2) Reduction, suspension, or termination or services prior to the member receiving the services previously authorized by the MCE;
   3) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the

Administrative Code;

4) Failure to act within the resolution timeframes specified in rule 5160-26-08.4 of the Administrative Code;
5) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable; or
6) Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination).

2. American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addiction and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
3. MCG – are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
4. Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:
   A. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat as adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
   B. Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased, or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.
   C. Conditions of medical necessity for a procedure, item, or service are met all the following apply:
      1) It meets generally accepted standards of medical practice;
      2) It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
      3) It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
      4) It is the lowest cost alternative that effectively addresses and treats the medical problem;
      5) It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
      6) It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.
   D. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.
   E. The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for

particular categories of service may be set forth within the Ohio Department of Medicaid (ODM) coverage policies or rules.

Change Summary

01/01/2025 New Policy.
08/05/2025 Annual Review, Coverage Change. Title Change Updated Coding Information