KAISER PERMANENTE® Mid-Atlantic States	**Mastectomy External Prosthesis Medical Coverage Policy**

UTILIZATION * ALERT*

- Coverage of external breast prosthesis is subject to availability of member's benefit.
- Before using this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to the Medicare Coverage Database for coverage.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. Procedure: **Mastectomy Prosthesis**

II. Specialty: External breast prosthetic device after a mastectomy

III. **Clinical Indications for Referral**

A. Indications of medical necessity and coverage

1. An authorization is required for breast prosthesis and associated durable medical equipment (DME) items within appropriate diagnoses and quantity limits.

2. KPMAS considers coverage of an externally worn breast prosthesis following a medically necessary mastectomy, partial mastectomy, or lumpectomy medically necessary for those members who have not had reconstructive surgery. This is covered regardless of when the medically necessary procedure was performed.

3. One external prosthetic device per side of the chest is considered medically necessary for the useful lifetime of the prosthesis.
   a. Post single mastectomy: one external breast prosthetic device is covered for the affected side; Coverage also includes breast prosthesis for the non-diseased breast to achieve symmetry.
   b. Post bilateral mastectomy: two prostheses (one per side) are considered medically necessary for bilateral mastectomies.

4. Breast form, which comes in a wide variety of types and designs, is considered medically necessary for the initial prosthesis and replacement prostheses.
   a. External silicone breast prosthesis – lifetime expectancy: 24 months;
   b. Non-silicone breast prosthesis (fabric, foam, or fiber filled) – lifetime expectancy: 6 months;
   c. Attachable breast;
   d. Post-surgical breast form in camisole;
   e. Partial breast prosthesis
   f. Nipple prosthesis - lifetime expectancy: 3 months

5. An external breast prosthesis garment, with mastectomy form is covered for use in the postoperative period as an alternative to mastectomy bra and breast prosthesis, or prior to permanent breast prosthesis.

6. A mastectomy bra or post-surgical camisole is covered for a patient who has a covered mastectomy form or silicone (or equal) breast prosthesis, when the pocket of the bra or camisole is used to hold the form/prosthesis.

7. A mastectomy sleeve is only covered if used as an adjunct to a course of treatment for post mastectomy lymphedema, otherwise it is non-covered since it does not meet the definition of prosthesis. For coverage, see Compression Bandages and Garments Medical Coverage Policy.

IV. Replacements, Limitations and Exclusions

A. Replacements of prostheses, mastectomy form and breast prosthesis garment are covered based on their medical necessity and their useful lifetime expectancy.
1. Replacements of silicone breast prostheses is every 24 months;
2. Replacements of non-silicone breast prostheses (fabric, foam, or fiber-filled) is every 6 months;
3. Replacement of an external breast prosthesis is covered at any time if the following conditions are met:
   a. An external breast prosthesis of the same type can be replaced at any time if irreparably damaged (not to include ordinary wear and tear) or defective; or
   b. An external breast prosthesis of a different type can be replaced at any time when medically appropriate due to a change in the patient's medical condition which requires or necessitates a different type of item.
4. Replacements of nipple prostheses is every 3 months;
5. A mastectomy bra or post-surgical camisole is limited to a maximum of up to four (4) per contract year; or as determined by the member's benefit plan and medical necessity.
6. The additional features of a custom-fabricated breast prosthesis, compared to a prefabricated silicone breast prosthesis, are generally not considered medically necessary. However, a custom fabricated prosthesis may be approved only if the member has coverage for this item under their EOC;
7. Benefit coverage and exclusions are subject to statutory or regulatory requirements and member's benefit plan for prosthetic devices.

B. The following have not been established to be medically necessary and considered non-covered.
1. More than one external breast prosthesis for each side of the chest except for appropriate replacements;
2. Repair or replacement of prosthesis sooner than their useful lifetime due to loss or misuse;

3. Breast prostheses, silicone or equal with integral adhesive have not been demonstrated to have a clinical advantage over those without the integral adhesive; and
4. Breast prostheses to correct congenital defects in breast symmetry is cosmetic and not medically necessary.

V. Procedures related to External Breast Prosthesis.

A. The procedure codes in this policy are only used as a guide. These codes are subject to change and do not necessarily indicate coverage.

HCPCS Codes	Procedures Description
A4280	Adhesive skin support attachment for use with external breast prosthesis
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
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
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8039	Breast prosthesis not otherwise specified

B. Definitions

1. Prosthesis or prosthetic device – is an artificial external device designed to perform, replace, substitute, or augment all or part of a permanently inoperative, missing, impaired or malfunctioning body part.
2. Breast prostheses – are breast forms which are intended to simulate breasts.
3. Initial prosthesis – the external breast prosthesis and mastectomy bra within the first year after mastectomy.
4. Breast form – an external prosthesis following a mastectomy or lumpectomy, either attached to the chest wall, worn against the skin, or inserted in the pocket of a mastectomy bra or garment.
5. External silicone breast prosthesis – a weighted silicone prosthesis, designed to simulate natural breast tissue.
6. Non-silicone breast prosthesis – a light-weight breast prosthesis, made of foam or fiberfill, which can be worn during exercise, swimming, and hot weather.
7. Attachable breast – a breast form that attaches securely to the chest wall with self-

adhesive strips.

8. Post-surgical form in camisole – a lightweight removable breast form that fits into a camisole garment, often worn immediately following mastectomy, lumpectomy, radiation therapy, or during reconstructive breast surgery.
9. Partial breast prosthesis – also called a "shaper" or "shell," is made of foam, fiberfill, or silicone and designed to be worn over the breast tissue to create a fuller appearance or enhance the overall size of the breast.
10. Nipple prosthesis – are silicone prosthesis resembling a nipple that clings securely to a breast. It can be worn for weeks following mastectomy, breast reconstruction or nipple reconstruction.
11. External Breast Prosthesis Garment – is a camisole type garment with polyester fill, used in the post-operative period prior to the permanent breast prosthesis or as an alternative to a mastectomy bra and/or breast prosthesis.
12. Post-mastectomy bra (or mastectomy bra) are bras with spandex stretch pockets on the inside to help hold or support the mastectomy form or breast prosthesis in place.

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Approval History

Effective June 01, 2016, state filing no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

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01/29/2019	01/29/2019
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*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any set of circumstances for an individual member.