Post Mastectomy Surgery

Policy Number: BIP177.K
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Instructions for Use

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Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Women's Health and Cancer Rights Act of 1988

- https://www.govinfo.gov/content/pkg/USCODE-2011-title29/html/USCODE-2011-title29-chap18-subchapI-subtitleB-part7-subpartB-sec1185b.htm
- https://www.congress.gov/bill/105th-congress/house-bill/616/text
- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet

Oklahoma

Title 36 Oklahoma Statues §6060.5 - "Oklahoma Breast Cancer Patient Protection Act"

http://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87363

a. This section shall be known and may be cited as the "Oklahoma Breast Cancer Patient Protection Act."
b. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1998, that provides medical and surgical benefits with respect to the treatment of breast cancer and other breast conditions shall ensure that coverage is provided for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.
c. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.
d. Any plan subject to subsection B of this section shall also provide coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the non-diseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast.

e. In implementing the requirements of this section, a health benefit plan may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required pursuant to subsections B and D of this section.
f. A health benefit plan shall provide notice to each insured or enrollee under the plan regarding the coverage required by this section in the evidence of coverage of the plan, and shall provide additional written notice of the coverage to the insured or enrollee as follows:
   1. In the next mailing made by the plan to the employee;
   2. As part of any yearly informational packet sent to the enrollee; or
   3. Not later than December 1, 1997; whichever is earlier.
   g. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.
   h. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

Oregon

743A.110 Mastectomy-Related Services; Expedited External Review Required

https://www.oregonlegislature.gov/bills_laws/ors/ors743A.html

(1) As used in this section, “mastectomy” means the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.
(2) All insurers offering a health benefit plan as defined in ORS 743B.005 (Definitions) shall provide payment, coverage or reimbursement for mastectomy and for the following services related to a mastectomy as determined by the attending physician and enrollee to be part of the enrollee’s course or plan of treatment:
   (a) All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;
   (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   (c) Prostheses;
   (d) Treatment of physical complications of the mastectomy, including lymphedemas; and
   (e) Inpatient care related to the mastectomy and post-mastectomy services.
(3) An insurer providing coverage under subsection (2) of this section shall provide written notice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and annually thereafter.
(4) A health benefit plan must provide a single determination of prior authorization for all services related to a mastectomy covered under subsection (2) of this section that are part of the enrollee’s course or plan of treatment.
(5) When an enrollee requests an external review of an adverse benefit determination as defined in ORS 743B.001 (Definitions) by the insurer regarding services described in subsection (2) of this section, the insurer or the Director of the Department of Consumer and Business Services must expedite the enrollee’s case pursuant to ORS 743B.252 (External review) (5).
(6) The coverage required under subsection (2) of this section is subject to the same terms and conditions in the plan that apply to other benefits under the plan.
(7) This section is exempt from ORS 743A.001 (Automatic repeal of certain statues on individual and group health insurance). [Formerly 743.691; 2011 c.208 §1; 2011 c.500 §41]

Texas

Texas Insurance Code § 1357.004 - Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1357.htm

a) A health benefit plan that provides coverage for mastectomy must provide coverage for:
   1) Reconstruction of the breast on which the mastectomy has been performed;
   2) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
   3) Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.
b) Coverage required under this section:
   1) Shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;
   2) May be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and
   3) May not be subject to dollar limits other than the lifetime maximum benefits under the plan.

Texas Insurance Code §1357.005 - Prohibited Conduct

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1357.htm

a) An issuer of a health benefit plan may not:
   1) Offer a financial incentive for an member to not receive breast reconstruction or to waive the coverage required under this subchapter;
   2) Condition, limit, or deny the eligibility of a person to enroll in the plan or to renew coverage under the terms of the plan solely to avoid the requirements of this subchapter; or
   3) Reduce or limit the reimbursement or amount paid to, or otherwise penalize, an attending physician or provider or provide a financial incentive or other benefit to an attending physician or provider to induce the physician or provider to provide care to an member in a manner that is inconsistent with this subchapter.

b) This section does not prevent an issuer of a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that the physician or provider will receive for care provided in accordance with this subchapter.

Texas Insurance Code §1357.054 - Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1357.htm

a) A health benefit plan that provides coverage for the treatment of breast cancer must provide to each enrollee coverage for inpatient care for a minimum of:
   1) 48 hours following a mastectomy; and
   2) 24 hours following a lymph node dissection for the treatment of breast cancer

b) A health benefit plan is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate.

TAC Title 28, Part 1, Chapter 11, Subchapter F Rule §11.508

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508

Each evidence of coverage must also include coverage for services as follows:

(b) (1) Breast reconstruction as required by federal law if the plan provides coverage for mastectomy, which is subject to the same deductible or copayment applicable to mastectomy, and which may not be denied because the mastectomy occurred before the effective date of coverage.

Washington

Revised Code of Washington §48.44.330 Breast Surgery

https://app.leg.wa.gov/RCW/default.aspx?cite=48.44.330

1) Each contract for health care entered into or renewed after July 24, 1983, between a health care services contractor and the person or persons to receive the care shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.
2) Each contract for health care entered into or renewed after January 1, 1986, between a health care services contractor and the person or persons to receive the care shall provide coverage for all stages of one reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.

Revised Code of Washington §48.44.335- Mastectomy, Lumpectomy

https://app.leg.wa.gov/RCW/default.aspx?cite=48.44.335

No health care service contractor under this chapter may refuse to issue any contract or cancel or decline to renew the contract solely because of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased, or reduced solely on the basis of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously.

Revised Code of Washington §48.20.397- Mastectomy, Lumpectomy

https://app.leg.wa.gov/RCW/default.aspx?cite=48.20.397

No person engaged in the business of insurance under this chapter may refuse to issue any contract of insurance or cancel or decline to renew the contract solely because of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased, or reduced solely on the basis of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the Medical Management Guideline titled Breast Reconstruction for details.

Not Covered

None

References

Women's Health and Cancer Rights Act of 1998

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
12/01/2023	All	• Routine review; no change to coverage guidelines • Archived previous policy version BIP177.J

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.