

Reconstructive Breast Surgery, Mastopexy, and Management of Breast Implants

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member.

The Medicare Advantage Medical Policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and the Centers of Medicare and Medicaid Services (CMS) policies, when available. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of CMS guidance for a requested service or procedure, the health plan may apply their Medical Policy Manual or MCG™ criteria, both of which are developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Medicare and EOCs exclude from coverage, among other things, services or procedures considered to be investigational, cosmetic, or not medically necessary, and in some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services.

DESCRIPTION

Reconstructive breast surgery is defined as a surgical procedure intended to restore the normal appearance of the breast after surgery, accidental injury, or trauma. The most common indication for reconstructive breast surgery is mastectomy. Cosmetic breast surgery is defined as surgery intended to alter or enhance the appearance of a breast when there is no functional impairment or which does not have a significantly altered appearance due to surgery, accidental injury, or trauma. The most common type of reconstructive breast surgery is insertion of a silicone gel-filled or saline-filled breast implant, either inserted immediately at the time of mastectomy - or sometime afterward in conjunction with the previous use of a tissue expander. Other types of reconstruction include nipple/areola reconstruction, nipple tattooing, and/or the use of autologous tissue (e.g., a transverse rectus abdominis myocutaneous flap [TRAM procedure] or a latissimus dorsi flap). In addition, mastopexy, reduction mammoplasty, or implant on the contralateral breast may be performed in order to achieve symmetry with the reconstructed breast.

MEDICARE ADVANTAGE POLICY CRITERIA

“Cosmetic surgery or expenses incurred in connection with such surgery is not covered.”
Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, [§120–Cosmetic Surgery](#)

Noridian Healthcare Solutions (Noridian) Local Coverage Article (LCD) L37020:

“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.”

Reduction mammoplasty for breast hypertrophy (macromastia) is not addressed in this Medicare Advantage Medical Policy. (See Medicare Advantage medical policy No. M-60, *Reduction Mammoplasty*).

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	For <i>breast reconstruction surgery of the affected and contralateral unaffected breast following a mastectomy performed for any medical reason (i.e., accidental injury, trauma, breast cancer, etc.):</i> ✓ Breast Reconstruction Following Mastectomy (140.2)
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	For <i>breast reconstruction procedures performed to reshape the breast when <u>unrelated</u> to breast cancer, as well as the removal of breast implants:</i> ✓ Plastic Surgery (L37020)

**Scroll to the “Public Version(s)” section at the bottom of the LCD or LCA for links to prior versions if necessary.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- Requested procedure (e.g., mastopexy, insertion or removal of implant, etc.);

- Indication for requested procedure, including all relevant medical history, signs and symptoms, and documentation of functional impairment, if any.

CROSS REFERENCES

[Gender Affirming Interventions for Gender Dysphoria](#), Medicine, Policy No. M-153

[Endometrial Ablation](#), Surgery, Policy No. M-01

[Cosmetic and Reconstructive Procedures](#), Surgery, Policy No. M-12

[Reduction Mammoplasty \(Mammoplasty\)](#), Surgery, Policy No. M-60

[Adipose-derived Stem Cell Enrichment In Autologous Fat Grafting to the Breast](#), Surgery, Policy No. M-182

REFERENCES

1. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, [§120 – Cosmetic Surgery](#)
2. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, [§180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare](#)

CODING

NOTE: Some codes listed may have specific criteria to be met in other Medicare Advantage medical policies (e.g., reduction mammoplasty), or may not be considered medically necessary for any indication. See Cross References to confirm the correct policy is applied. In addition, CPT code 20926 is the recommended code when autologous fat grafting is used for reconstructive breast surgery. For autologous fat grafting **with additional** adipose-derived stem cells (aka, stem cell enrichment), see Cross References to confirm correct criteria is applied.

Codes	Number	Description
CPT	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq. cm or less
	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
	11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
	11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
	11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
	11970	Replacement of tissue expander with permanent prosthesis
	11971	Removal of tissue expander(s) without insertion of prosthesis
	19316	Mastopexy
	19318	Reduction mammoplasty

Codes	Number	Description
	19324	Mammoplasty, augmentation; without prosthetic implant
	19325	Mammoplasty, augmentation; with prosthetic implant
	19328	Removal of intact mammary implant
	19330	Removal of mammary implant material
	19340	Immediate insertion of breast prosthesis following mastopexy,
	19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	19357	Breast reconstruction, immediate or delayed, with tissue expander, implant
	19361	Breast reconstruction with latissimus dorsi flap, without prosthetic
	19364	Breast reconstruction with free flap
	19366	Breast reconstruction with other technique
	19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM) single pedicle, including closure of donor site
	19368	; with microvascular anastomosis (supercharging)
	19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM) double pedicle, including closure of donor site
	19370	Open periprosthetic capsulotomy, breast
	19371	Periprosthetic capsulotomy, breast
	19380	Revision of reconstructed breast
	19396	Preparation of moulage for custom breast implant
	19499	Unlisted procedure, breast
	20926	Tissue grafts, other (e.g., paratenon, fat, dermis)
HCPCS	L8039	Breast prosthesis, not otherwise specified
	L8600	Implantable breast prosthesis, silicone or equal
	S2066	Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral (<i>Not recognized by Medicare for payment</i>)
	S2067	Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral (<i>Not recognized by Medicare for payment</i>)
	S2068	Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral (<i>Not recognized by Medicare for payment</i>)

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.