

Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants

Effective: August 1, 2019

Next Review: August 2020

Last Review: July 2019

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Policy provides breast reconstruction and implant management criteria based on Public Law 105-277, the Women's Health and Cancer Rights Act of 1998.

MEDICAL POLICY CRITERIA

Notes:

- Contractual limitations and exclusions may apply to both reconstructive and cosmetic procedures, to illnesses and conditions initially occurring prior to coverage, and to complications of non-covered procedures.
- For the purposes of this policy, mastectomy is defined as complete or partial, including lumpectomy.
- Some codes listed may have specific criteria to be met in other 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.

- I. Reconstructive breast surgery of a diseased or injured breast may be considered **medically necessary** when either of the following criteria is met and the treating

physician recommends it:

- A. After prophylactic or therapeutic mastectomy
 - B. After accidental injury or trauma to the breast
- II. Reconstructive breast surgery of an unaffected breast to achieve symmetry with the contralateral breast may be considered **medically necessary** when reconstruction of the contralateral diseased or injured breast was medically necessary as defined in Criterion I above and it is recommended by the treating physician.
- III. Breast implant explantation is considered **medically necessary** when the implant(s) was/were placed during reconstructive breast surgery that was medically necessary as defined in Criterion I. Explantation of implant(s) requires documentation of the original indication for implantation.
- IV. Breast revision surgery following a cosmetic primary breast procedure, is considered **cosmetic** when medical necessity Criteria (I, II, or III) are not met.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

CROSS REFERENCES

1. [Gender Affirming Interventions for Gender Dysphoria](#), Medicine, Policy No. 153
2. [Endometrial Ablation](#), Surgery, Policy No. 01
3. [Cosmetic and Reconstructive Surgery](#), Surgery, Policy No. 12
4. [Reduction Mammoplasty](#), Surgery, Policy No. 60
5. [Adipose-derived Stem Cell Enrichment in Autologous Fat Grafting to the Breast](#), Surgery, Policy No. 182

BACKGROUND

Reconstructive breast surgery is defined as those surgical procedures which are 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. In contrast, cosmetic breast surgery is defined as surgery intended to alter or enhance the appearance of a breast which does not have a significantly altered appearance due to surgery, accidental injury, or trauma. Reduction mammoplasty and surgery to alter the appearance of a congenital breast abnormality are examples of breast surgeries which may be cosmetic. (See Surgery Policy No. 60, Reduction Mammoplasty and Surgery Policy No. 12, Cosmetic and Reconstructive Surgery). 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. Significant local complications of breast implants, such as contracture, may require removal of the implant. Other types of reconstruction include nipple/areola reconstruction, nipple tattooing, and/or the use of autologous tissue, such as 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.

POSITION STATEMENT

This policy is written to assist in interpreting Public Law 105-277, the Women's Health and Cancer Rights Act of 1998^[1] which requires all health insurance carriers that cover mastectomies to also cover the following in a manner determined in consultation with the attending physician and patient:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the contralateral breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy, including lymphedema

REFERENCES

1. Your Rights After A Mastectomy...Women's Health & Cancer Rights Act of 1998. [cited 7/25/2018]; Available from: <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf>

CODES

NOTE: 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
	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, mastectomy, or in reconstruction
	19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples

Codes	Number	Description
	19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
	19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
	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
	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
	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

Date of Origin: January 1996