Regence

Medical Policy Manual Surgery, Policy No. 40

Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants

Effective: October 1, 2026

Next Review: August 2027
Last Review: August 2026

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 not specified below.
- 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 mammaplasty), or may not be considered medically necessary for any indication. See Cross References to confirm the correct policy is applied.
- This policy does not address procedures related to gender affirming interventions for gender dysphoria. See Cross References for the correct policy to be applied.

- Clinical documentation to support criteria is required (See Required Documentation)

Medically Necessary

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; or

   B. After accidental injury or trauma to the breast resulting in significant malformation

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 and/or replacement may be 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. Breast implant explantation may be unilateral or bilateral when performed during the same procedure.

IV. Breast implant(s) explantation may be considered **medically necessary** when there is a pathologically confirmed diagnosis of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) or breast implant-associated squamous cell carcinoma (BIA-SCC).

Cosmetic

V. Breast revision surgery, including breast implant explantation and/or replacement, following a cosmetic primary breast procedure is considered **cosmetic** when one or more of Criteria I., II., III., or IV is not met.

VI. Mastopexy 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.

REQUIRED DOCUMENTATION

It is critical that the list of information below is submitted for review to determine if the policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and physical/chart notes
- For implant explantation requests due to breast-implant associated malignancy, pathologic confirmation of a diagnosis of breast implant associated anaplastic large cell lymphoma (BIA-ALCL) or breast implant-associated squamous cell carcinoma (BIA-SCC) from:
    - Pre-operative percutaneous needle aspiration of seroma, or

- Needle biopsy of a mass, if present

Note: Imaging modalities suggesting the diagnosis of breast implant-associated malignancy are not sufficient.

CROSS REFERENCES

1. Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. 153
2. Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products, Medicine, Policy No. 170
3. Endometrial Ablation, Surgery, Policy No. 01
4. Cosmetic and Reconstructive Surgery, Surgery, Policy No. 12
5. Reduction Mammaplasty, Surgery, Policy No. 60
6. 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

SUMMARY

Medically Necessary

Reconstructive breast surgery of a diseased or injured breast may be considered medically necessary after prophylactic or therapeutic mastectomy or after accidental injury or trauma to the breast resulting in significant malformation when the treating physician recommends it.

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 policy criteria and it is recommended by the treating physician.

Breast implant explantation and/or replacement may be considered medically necessary when the implant(s) was/were placed during reconstructive breast surgery that was medically necessary as defined in policy criteria.

Breast implant explantation may be considered medically necessary when there is a pathologically confirmed diagnosis of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) or breast implant-associated squamous cell carcinoma (BIA-SCC).

Cosmetic

Breast revision surgery, including breast implant explantation and/or replacement, following a cosmetic primary breast procedure is considered cosmetic when medical necessity criteria are not met.

Mastopexy is considered cosmetic when medical necessity criteria are not met.

REFERENCES

1. Your Rights After A Mastectomy...Women's Health & Cancer Rights Act of 1998. [cited 10/07/2025]. 'Available from:' https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/your-rights-after-a-mastectomy.pdf.

CODES

Notes:

Codes 15769, 15771, and 15772 should be reported for autologous fat grafting for reconstructive breast surgery.

- CPT codes 11950, 11951, 11952, and 11954 [subcutaneous injection of filling material (eg, collagen)], 19366 (breast flap graft other technique), 19380 (revision of reconstructed breast), and 19499 (unlisted code) are not reported for breast fat grafting.
- 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
	11970	Replacement of tissue expander with permanent implant
	11971	Removal of tissue expander(s) without insertion of implant

Codes	Number	Description
	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
	15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
	15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
	19316	Mastopexy
	19318	Breast reduction
	19325	Breast augmentation with implant
	19328	Removal of intact breast implant
	19330	Removal of ruptured implant, including implant contents (eg, saline, silicone gel)
	19340	Insertion of breast implant on same day of mastectomy, (ie, immediate)
	19342	Insertion or replacement of breast implant on separate day from mastectomy
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
	19361	Breast reconstruction; with latissimus dorsi flap
	19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
	19367	Breast reconstruction; with single-pedicle transverse rectus abdominis myocutaneous (TRAM) flap
	19368	; requiring separate microvascular anastomosis (supercharging)
	19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
	19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
	19371	Peri-implant capsulotomy, 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
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
CPT	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq. cm or less

Date of Origin: *January 1996*