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Medicare Advantage Policy Manual **Policy ID:** M-SUR40

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, including care that may be both medically reasonable and necessary.

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 Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. 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 a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual but they may also be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). 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. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

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

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

CMS Coverage Manuals

None

National Coverage Determinations (NCDs)

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

For ***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.)***:

- ✓ Breast Reconstruction Following Mastectomy (140.2)

Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

For ***breast reconstruction procedures performed to reshape the breast when unrelated to breast cancer, as well as the removal of breast implants:***

- ✓ Plastic Surgery (L35163) *(Companion article is* A57221*, which can be accessed directly from the LCD)*

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

POLICY GUIDELINES

"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

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

1. Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. M-153
2. Cosmetic and Reconstructive Procedures, Surgery, Policy No. M-12
3. Reduction Mammaplasty (Mammoplasty), Surgery, Policy No. M-60
4. 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 mammaplasty), 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 implant
	11971	Removal of tissue expander without insertion of implant
	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 breast implant, including implant contents (eg, saline, silicone gel)
	19340	Insertion of breast implant on separate day from mastectomy
	19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction
	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 pedicled transverse rectus abdominis myocutaneous (TRAM) flap
	19368	; with single pedicled transverse rectus abdominis myocutaneous (TRAM) flap, 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 capsulectomy, 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 *(Not recognized by Medicare for payment)*

	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 *(Not recognized by Medicare for payment)*
	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 *(Not recognized by Medicare for payment)*