



MASSACHUSETTS

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Medical Policy

Reconstructive Breast Surgery/Management of Breast Implants

Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [Authorization Information](#)
- [Coding Information](#)
- [Description](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [References](#)
- [Endnotes](#)

Policy Number: 428

BCBSA Reference Number: 7.01.22 (For Plan internal use only)

Related Policies

Bio-Engineered Skin and Soft Tissue Substitutes, [#663](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Reconstructive surgery (including but not limited to augmentation and reduction mammoplasty) may be considered **MEDICALLY NECESSARY** for Poland's Syndrome (congenital absence of one breast), or severe breast asymmetry (a minimum of 1 cup size difference*) when the following criteria are met:

- Documented tanner stage IV or V for members aged 15-18, **AND**
- Stable height measurements for 6 months, **OR**
- Puberty completion as shown on wrist radiograph.

Surgery on the contralateral breast is a once in a lifetime benefit only.

*130 to 150 cc implant equates to a one-cup-size increase

Augmentation mammoplasty is **NOT MEDICALLY NECESSARY** to enlarge small but otherwise normal and symmetrical breasts, or to create symmetry between normal breasts.¹

Augmentation mammoplasty revision is only **MEDICALLY NECESSARY** for complications of an initial surgery. If the initial surgery is not medically necessary, revision for complications is still covered.¹

Reconstructive breast surgery may be considered **MEDICALLY NECESSARY** after a medically necessary mastectomy, accidental injury, or trauma. Medically necessary mastectomies are most typically done as treatment for cancer. Reconstruction may be performed by an implant-based approach or through the use of autologous tissue.¹

Revision of a reconstructive breast surgery may be considered **MEDICALLY NECESSARY** if the original surgery met the above criteria for reconstruction and there was either

- a complication from the original surgery that needs correction, or

- the original reconstruction is normally performed in stages, or
- the member has a diagnosis of breast cancer.

Explantation of a **silicone gel-filled** breast implant may be considered **MEDICALLY NECESSARY** in all cases for a documented implant rupture, infection, extrusion, Baker class IV contracture, or as an adjunct to surgical treatment of breast cancer.

Explantation of a ruptured **saline-filled** breast implant may be considered **MEDICALLY NECESSARY** only in those individuals who had originally undergone breast implantation for reconstructive purposes. Otherwise, indications for the explantation of a saline-filled implant are similar to those of a silicone-filled implant (i.e., infection, extrusion, Baker class IV contracture, or surgical treatment of breast cancer).

Explantation of a breast implant associated with a Baker class III contracture may be considered **MEDICALLY NECESSARY** only in those individuals who had originally undergone breast implantation for reconstructive purposes.

Reconstructive breast surgery after explantation of an implant is considered **MEDICALLY NECESSARY** only in those individuals who had originally undergone breast implantation for reconstructive purposes.

The following indications for explantation of implants are considered **INVESTIGATIONAL**

- Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases
- Anxiety
- Baker class III contractures in individuals with implants for cosmetic purposes
- Rupture of a saline implant in individuals with implants for cosmetic purposes
- Pain not related to contractures
- Preventive explantation in asymptomatic individuals to reduce remote risk of anaplastic large cell lymphoma
- Preventive explantation in asymptomatic individuals to reduce remote risk of B cell lymphoma.

Implant repositioning to reposition a displaced implant is **NOT MEDICALLY NECESSARY**.¹

Nipple inversion correction is **NOT MEDICALLY NECESSARY**.¹

Mastopexy to correct sagging breasts is **NOT MEDICALLY NECESSARY**.¹

Breast Reconstruction after Mastectomy²

Reconstruction after mastectomy, breast conservation therapy and diagnostic deformity of the breast is considered **MEDICALLY NECESSARY** on the affected breast:

- When performed in connection with breast cancer, the evaluation of breast cancer, the evaluation of suspected breast cancer, or the prevention of breast cancer development in high risk individuals; OR
- For prostheses and physical complications of all stages of mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity, including lymphedema treatment.
 - Physical complications of a staged mastectomy may include, but is not limited to, abdominal scar revision/release related to prior tissue needed for breast reconstruction.

Reconstruction after mastectomy, breast conservation therapy and diagnostic deformity of the breast is considered **MEDICALLY NECESSARY** on the un-affected breast in order to create a symmetrical appearance.

Tattooing of the areola as part of nipple reconstruction following a covered mastectomy is considered **MEDICALLY NECESSARY**.

The following procedures are considered **MEDICALLY NECESSARY** in accordance with the Women's Health and Cancer Rights Act of 1998, when performed as a breast reconstruction procedure following or in connection with mastectomy, breast conservation therapy (BCT) or other diagnostic procedures

causing deformity of the breast, in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk individuals:

- Allograft material for use in breast reconstructive surgery
- Implant repositioning
- Inverted Nipple Correction
- Mastopexy.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is required .
Commercial PPO	Prior authorization is required .

Requesting Prior Authorization Using Authorization Manager

Providers will need to use [Authorization Manager](#) to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the service request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

Refer to our [Authorization Manager](#) page for tips, guides, and video demonstrations.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
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

11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander(s) without insertion of implant
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 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-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; 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
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

HCPCS Codes

HCPCS codes:	Code Description
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

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0H0T07Z	Alteration Of Right Breast With Autologous Tissue Substitute, Open Approach
0H0T0JZ	Alteration Of Right Breast With Synthetic Substitute, Open Approach
0H0T37Z	Alteration Of Right Breast With Autologous Tissue Substitute, Percutaneous Approach
0H0T3JZ	Alteration Of Right Breast With Synthetic Substitute, Percutaneous Approach

0H0U07Z	Alteration Of Left Breast With Autologous Tissue Substitute, Open Approach
0H0U0JZ	Alteration Of Left Breast With Synthetic Substitute, Open Approach
0H0U37Z	Alteration Of Left Breast With Autologous Tissue Substitute, Percutaneous Approach
0H0U3JZ	Alteration Of Left Breast With Synthetic Substitute, Percutaneous Approach
0H0V07Z	Alteration Of Bilateral Breast With Autologous Tissue Substitute, Open Approach
0H0V0JZ	Alteration Of Bilateral Breast With Synthetic Substitute, Open Approach
0H0V37Z	Alteration Of Bilateral Breast With Autologous Tissue Substitute, Percutaneous Approach
0H0V3JZ	Alteration Of Bilateral Breast With Synthetic Substitute, Percutaneous Approach
0HBT0ZZ	Excision Of Right Breast, Open Approach
0HBT3ZZ	Excision Of Right Breast, Percutaneous Approach
0HBU0ZZ	Excision Of Left Breast, Open Approach
0HBU3ZZ	Excision Of Left Breast, Percutaneous Approach
0HBV0ZZ	Excision Of Bilateral Breast, Open Approach
0HBV3ZZ	Excision Of Bilateral Breast, Percutaneous Approach
0HHT0NZ	Insertion Of Tissue Expander Into Right Breast, Open Approach
0HHT3NZ	Insertion Of Tissue Expander Into Right Breast, Percutaneous Approach
0HHT7NZ	Insertion Of Tissue Expander Into Right Breast, Via Natural Or Artificial Opening
0HHT8NZ	Insertion Of Tissue Expander Into Right Breast, Via Natural Or Artificial Opening Endoscopic
0HHU0NZ	Insertion Of Tissue Expander Into Left Breast, Open Approach
0HHU3NZ	Insertion Of Tissue Expander Into Left Breast, Percutaneous Approach
0HHU7NZ	Insertion Of Tissue Expander Into Left Breast, Via Natural Or Artificial Opening
0HHU8NZ	Insertion Of Tissue Expander Into Left Breast, Via Natural Or Artificial Opening Endoscopic
0HHV0NZ	Insertion Of Tissue Expander Into Bilateral Breast, Open Approach
0HHV3NZ	Insertion Of Tissue Expander Into Bilateral Breast, Percutaneous Approach
0HHV7NZ	Insertion Of Tissue Expander Into Bilateral Breast, Via Natural Or Artificial Opening
0HHV8NZ	Insertion Of Tissue Expander Into Bilateral Breast, Via Natural Or Artificial Opening Endoscopic
0HHW0NZ	Insertion Of Tissue Expander Into Right Nipple, Open Approach
0HHW3NZ	Insertion Of Tissue Expander Into Right Nipple, Percutaneous Approach
0HHW7NZ	Insertion Of Tissue Expander Into Right Nipple, Via Natural Or Artificial Opening
0HHW8NZ	Insertion Of Tissue Expander Into Right Nipple, Via Natural Or Artificial Opening Endoscopic
0HHX0NZ	Insertion Of Tissue Expander Into Left Nipple, Open Approach
0HHX3NZ	Insertion Of Tissue Expander Into Left Nipple, Percutaneous Approach
0HHX7NZ	Insertion Of Tissue Expander Into Left Nipple, Via Natural Or Artificial Opening
0HHX8NZ	Insertion Of Tissue Expander Into Left Nipple, Via Natural Or Artificial Opening Endoscopic
0HMWXZZ	Reattachment Of Right Nipple, External Approach
0HMXXZZ	Reattachment Of Left Nipple, External Approach
0HPT0JZ	Removal Of Synthetic Substitute From Right Breast, Open Approach
0HPT0NZ	Removal Of Tissue Expander From Right Breast, Open Approach
0HPT3JZ	Removal Of Synthetic Substitute From Right Breast, Percutaneous Approach
0HPT3NZ	Removal Of Tissue Expander From Right Breast, Percutaneous Approach
0HPU0JZ	Removal Of Synthetic Substitute From Left Breast, Open Approach
0HPU0NZ	Removal Of Tissue Expander From Left Breast, Open Approach
0HPU3JZ	Removal Of Synthetic Substitute From Left Breast, Percutaneous Approach
0HPU3NZ	Removal Of Tissue Expander From Left Breast, Percutaneous Approach
0HQT0ZZ	Repair Right Breast, Open Approach
0HQT3ZZ	Repair Right Breast, Percutaneous Approach
0HQT7ZZ	Repair Right Breast, Via Natural Or Artificial Opening

0HQT8ZZ	Repair Right Breast, Via Natural Or Artificial Opening Endoscopic
0HQU0ZZ	Repair Left Breast, Open Approach
0HQU3ZZ	Repair Left Breast, Percutaneous Approach
0HQU7ZZ	Repair Left Breast, Via Natural Or Artificial Opening
0HQU8ZZ	Repair Left Breast, Via Natural Or Artificial Opening Endoscopic
0HQW0ZZ	Repair Right Nipple, Open Approach
0HQW0ZZ	Repair Right Nipple, Open Approach
0HQW3ZZ	Repair Right Nipple, Percutaneous Approach
0HQW3ZZ	Repair Right Nipple, Percutaneous Approach
0HQW7ZZ	Repair Right Nipple, Via Natural Or Artificial Opening
0HQW7ZZ	Repair Right Nipple, Via Natural Or Artificial Opening
0HQW8ZZ	Repair Right Nipple, Via Natural Or Artificial Opening Endoscopic
0HQW8ZZ	Repair Right Nipple, Via Natural Or Artificial Opening Endoscopic
0HQWXZZ	Repair Right Nipple, External Approach
0HQWXZZ	Repair Right Nipple, External Approach
0HQX0ZZ	Repair Left Nipple, Open Approach
0HQX0ZZ	Repair Left Nipple, Open Approach
0HQX3ZZ	Repair Left Nipple, Percutaneous Approach
0HQX3ZZ	Repair Left Nipple, Percutaneous Approach
0HQX7ZZ	Repair Left Nipple, Via Natural Or Artificial Opening
0HQX7ZZ	Repair Left Nipple, Via Natural Or Artificial Opening
0HQX8ZZ	Repair Left Nipple, Via Natural Or Artificial Opening Endoscopic
0HQX8ZZ	Repair Left Nipple, Via Natural Or Artificial Opening Endoscopic
0HQXXZZ	Repair Left Nipple, External Approach
0HQXXZZ	Repair Left Nipple, External Approach
0HRT075	Replacement Of Right Breast Using Latissimus Dorsi Myocutaneous Flap, Open Approach
0HRT076	Replacement Of Right Breast Using Transverse Rectus Abdominis Myocutaneous Flap, Open Approach
0HRT077	Replacement Of Right Breast Using Deep Inferior Epigastric Artery Perforator Flap, Open Approach
0HRT078	Replacement Of Right Breast Using Superficial Inferior Epigastric Artery Flap, Open Approach
0HRT079	Replacement Of Right Breast Using Gluteal Artery Perforator Flap, Open Approach
0HRT07Z	Replacement Of Right Breast With Autologous Tissue Substitute, Open Approach
0HRT0JZ	Replacement Of Right Breast With Synthetic Substitute, Open Approach
0HRT0JZ	Replacement Of Right Breast With Synthetic Substitute, Open Approach
0HRT37Z	Replacement Of Right Breast With Autologous Tissue Substitute, Percutaneous Approach
0HRT3JZ	Replacement Of Right Breast With Synthetic Substitute, Percutaneous Approach
0HRU075	Replacement Of Left Breast Using Latissimus Dorsi Myocutaneous Flap, Open Approach
0HRU076	Replacement Of Left Breast Using Transverse Rectus Abdominis Myocutaneous Flap, Open Approach
0HRU077	Replacement Of Left Breast Using Deep Inferior Epigastric Artery Perforator Flap, Open Approach
0HRU078	Replacement Of Left Breast Using Superficial Inferior Epigastric Artery Flap, Open Approach
0HRU079	Replacement Of Left Breast Using Gluteal Artery Perforator Flap, Open Approach
0HRU07Z	Replacement Of Left Breast With Autologous Tissue Substitute, Open Approach
0HRU0JZ	Replacement Of Left Breast With Synthetic Substitute, Open Approach
0HRU0JZ	Replacement Of Left Breast With Synthetic Substitute, Open Approach

0HRU37Z	Replacement Of Left Breast With Autologous Tissue Substitute, Percutaneous Approach
0HRU3JZ	Replacement Of Left Breast With Synthetic Substitute, Percutaneous Approach
0HRV075	Replacement Of Bilateral Breast Using Latissimus Dorsi Myocutaneous Flap, Open Approach
0HRV076	Replacement Of Bilateral Breast Using Transverse Rectus Abdominis Myocutaneous Flap, Open Approach
0HRV077	Replacement Of Bilateral Breast Using Deep Inferior Epigastric Artery Perforator Flap, Open Approach
0HRV078	Replacement Of Bilateral Breast Using Superficial Inferior Epigastric Artery Flap, Open Approach
0HRV079	Replacement Of Bilateral Breast Using Gluteal Artery Perforator Flap, Open Approach
0HRV37Z	Replacement Of Bilateral Breast With Autologous Tissue Substitute, Percutaneous Approach
0HRW07Z	Replacement Of Right Nipple With Autologous Tissue Substitute, Open Approach
0HRW0JZ	Replacement Of Right Nipple With Synthetic Substitute, Open Approach
0HRW37Z	Replacement Of Right Nipple With Autologous Tissue Substitute, Percutaneous Approach
0HRW3JZ	Replacement Of Right Nipple With Synthetic Substitute, Percutaneous Approach
0HRWX7Z	Replacement Of Right Nipple With Autologous Tissue Substitute, External Approach
0HRWXJZ	Replacement Of Right Nipple With Synthetic Substitute, External Approach
0HRX07Z	Replacement Of Left Nipple With Autologous Tissue Substitute, Open Approach
0HRX0JZ	Replacement Of Left Nipple With Synthetic Substitute, Open Approach
0HRX37Z	Replacement Of Left Nipple With Autologous Tissue Substitute, Percutaneous Approach
0HRX3JZ	Replacement Of Left Nipple With Synthetic Substitute, Percutaneous Approach
0HRXX7Z	Replacement Of Left Nipple With Autologous Tissue Substitute, External Approach
0HRXXJZ	Replacement Of Left Nipple With Synthetic Substitute, External Approach
0HST0ZZ	Reposition Right Breast, Open Approach
0HSU0ZZ	Reposition Left Breast, Open Approach
0HSV0ZZ	Reposition Bilateral Breast, Open Approach
0HUT0JZ	Supplement Right Breast With Synthetic Substitute, Open Approach
0HUT3JZ	Supplement Right Breast With Synthetic Substitute, Percutaneous Approach
0HUU0JZ	Supplement Left Breast With Synthetic Substitute, Open Approach
0HUU3JZ	Supplement Left Breast With Synthetic Substitute, Percutaneous Approach
0HUV0JZ	Supplement Bilateral Breast With Synthetic Substitute, Open Approach
0HUV3JZ	Supplement Bilateral Breast With Synthetic Substitute, Percutaneous Approach
0HUUW07Z	Supplement Right Nipple With Autologous Tissue Substitute, Open Approach
0HUUW0JZ	Supplement Right Nipple With Synthetic Substitute, Open Approach
0HUUW37Z	Supplement Right Nipple With Autologous Tissue Substitute, Percutaneous Approach
0HUUW3JZ	Supplement Right Nipple With Synthetic Substitute, Percutaneous Approach
0HUUW77Z	Supplement Right Nipple With Autologous Tissue Substitute, Via Natural Or Artificial Opening
0HUUW7JZ	Supplement Right Nipple With Synthetic Substitute, Via Natural Or Artificial Opening
0HUUW87Z	Supplement Right Nipple With Autologous Tissue Substitute, Via Natural Or Artificial Opening Endoscopic
0HUUW8JZ	Supplement Right Nipple With Synthetic Substitute, Via Natural Or Artificial Opening Endoscopic
0HUUWX7Z	Supplement Right Nipple With Autologous Tissue Substitute, External Approach
0HUUWXJZ	Supplement Right Nipple With Synthetic Substitute, External Approach
0HUX07Z	Supplement Left Nipple With Autologous Tissue Substitute, Open Approach
0HUX0JZ	Supplement Left Nipple With Synthetic Substitute, Open Approach
0HUX37Z	Supplement Left Nipple With Autologous Tissue Substitute, Percutaneous Approach
0HUX3JZ	Supplement Left Nipple With Synthetic Substitute, Percutaneous Approach

0HUX77Z	Supplement Left Nipple With Autologous Tissue Substitute, Via Natural Or Artificial Opening
0HUX7JZ	Supplement Left Nipple With Synthetic Substitute, Via Natural Or Artificial Opening
0HUX87Z	Supplement Left Nipple With Autologous Tissue Substitute, Via Natural Or Artificial Opening Endoscopic
0HUX8JZ	Supplement Left Nipple With Synthetic Substitute, Via Natural Or Artificial Opening Endoscopic
0HUXX7Z	Supplement Left Nipple With Autologous Tissue Substitute, External Approach
0HUXXJZ	Supplement Left Nipple With Synthetic Substitute, External Approach
0HWT0JZ	Revision Of Synthetic Substitute In Right Breast, Open Approach
0HWT3JZ	Revision Of Synthetic Substitute In Right Breast, Percutaneous Approach
0HWU0JZ	Revision Of Synthetic Substitute In Left Breast, Open Approach
0HWU3JZ	Revision Of Synthetic Substitute In Left Breast, Percutaneous Approach
0HX5XZZ	Transfer Chest Skin, External Approach
0JD83ZZ	Extraction Of Abdomen Subcutaneous Tissue And Fascia, Percutaneous Approach
0JD93ZZ	Extraction Of Buttock Subcutaneous Tissue And Fascia, Percutaneous Approach
0JDL3ZZ	Extraction Of Right Upper Leg Subcutaneous Tissue And Fascia, Percutaneous Approach
0JDM3ZZ	Extraction Of Left Upper Leg Subcutaneous Tissue And Fascia, Percutaneous Approach
0KXH0ZZ	Transfer Right Thorax Muscle, Open Approach
0KXH4ZZ	Transfer Right Thorax Muscle, Percutaneous Endoscopic Approach
0KXJ0ZZ	Transfer Left Thorax Muscle, Open Approach
0KXJ4ZZ	Transfer Left Thorax Muscle, Percutaneous Endoscopic Approach
0KXK0Z6	Transfer Right Abdomen Muscle, Transverse Rectus Abdominis Myocutaneous Flap, Open Approach
0KXK4Z6	Transfer Right Abdomen Muscle, Transverse Rectus Abdominis Myocutaneous Flap, Percutaneous Endoscopic Approach
0KXL0Z6	Transfer Left Abdomen Muscle, Transverse Rectus Abdominis Myocutaneous Flap, Open Approach
0KXL4Z6	Transfer Left Abdomen Muscle, Transverse Rectus Abdominis Myocutaneous Flap, Percutaneous Endoscopic Approach
3E00XMZ	Introduction Of Pigment Into Skin And Mucous Membranes, External Approach

Description

Reconstructive breast surgery is defined as a surgical procedure that is designed to restore the normal appearance of the breast after surgery, accidental injury, or trauma. Breast reconstruction is distinguished from purely cosmetic procedures by the presence of a medical condition, e.g., breast cancer or trauma, which leads to the need for breast reconstruction.

The most common indication for reconstructive breast surgery is a prior mastectomy; in fact, benefits for reconstructive breast surgery in these individuals are a mandated benefit in many states. In contrast, cosmetic breast surgery is defined as surgery designed to alter or enhance the appearance of a breast that has not undergone surgery, accidental injury, or trauma. Reduction mammoplasty is a common example of cosmetic breast surgery, but surgery to alter the appearance of a congenital abnormality of the breasts, such as tubular breasts, would also be considered cosmetic in nature.

There is a broadening array of surgical approaches to breast reconstruction. The most common is insertion of a breast implant, either a silicone gel-filled or saline-filled prosthesis. The implant is either inserted immediately at the time of mastectomy (CPT code 19340) or sometime afterward in conjunction with the previous use of a tissue expander (19342, 19357).

The breast may also be reconstructed using autologous tissues, such as a free flap (19364), a latissimus dorsi flap (19361), or more commonly using a transverse rectus abdominis flap (TRAM procedure, 19367,

19369). Nipple areola reconstruction (19350) or nipple tattooing (11920) may also be considered reconstructive breast surgery. Since the purpose of reconstructive breast surgery is to restore the normal appearance of the breast, on some occasions procedures are performed on the contralateral, normal breast to achieve symmetry, such as mastopexy (19316) and reduction mammoplasty (19318). These procedures fall into the category of reconstructive breast surgery only when performed in conjunction with a contralateral mastectomy for cancer with associated reconstruction. Except for medically necessary reduction mammoplasty, these procedures are considered cosmetic in other circumstances. The following policy describes different types of reconstructive breast surgery and reviews the evidence on efficacy for the different approaches. It also establishes criteria for the explantation of breast implants based on whether the original implant was cosmetic or reconstructive in nature, and whether the implant is silicone gel-filled or saline-filled.

Summary

Breast reconstruction is intended for individuals undergoing mastectomy for breast cancer, or who have an injury or trauma to the breasts. For the general population of women undergoing mastectomy, the evidence supports the conclusion that breast reconstruction improves psychosocial outcomes, such as anxiety, social functioning, and perception of body image. Thus, breast reconstruction may be considered medically necessary when reconstruction is needed as a result of breast cancer, injury, or trauma.

Important clinical questions remain concerning the optimal timing of breast reconstruction in women undergoing radiotherapy and concerning which of the surgical approaches leads to better outcomes. For women undergoing radiotherapy following mastectomy, the evidence is not sufficient to determine whether immediate or delayed surgery is preferred. The evidence is also not sufficient to determine the comparative efficacy of different procedures. There is some evidence that an autologous tissue approach leads to better cosmetic outcomes in individuals receiving radiotherapy, but this is not from high-quality evidence and is not a consistent finding across studies.

Breast implants can be used as part of breast reconstruction, or for cosmetic reasons. Local complications of breast implants are common and may lead to explantation. The medical necessity of implant explantation is dependent on the type of implant, the indication for removal, and the original indication for implantation.

For asymptomatic individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, or surgical treatment of breast cancer who receive preventive breast implant explantation to reduce remote risk of anaplastic large cell lymphoma (ALCL), the evidence includes prospective and retrospective epidemiological cohort studies, case series, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Systematic reviews of epidemiological studies and government regulatory epidemiologic databases have evaluated the risk of breast implant-associated ALCL (BIA-ALCL). Estimates varied widely, with the highest incidence associated with textured implant products that are no longer marketed in the United States. The certainty of the evidence is limited by insufficient follow-up duration to assess risk and lack of standardization of clinical outcome data collection. Additionally, there is no evidence evaluating whether removal of implants reduces ALCL risk, and there are known risks of explantation surgery. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, or surgical treatment of breast cancer who receive preventive breast implant explantation to reduce remote risk of B cell lymphoma, the evidence includes case reports. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Recent case reports and small case series (N=3 to 8 cases) have described B cell lymphomas occurring in individuals with breast implants. More data are needed to determine if breast implants are associated with an increased risk of B cell lymphoma. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
8/2023	Annual policy review. Policy clarified. Medically necessary statement on explantation of a silicone gel-filled breast implant clarified as an adjunct surgical treatment of breast cancer.
1/2023	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
11/2022	Annual policy review. New indications and investigational policy statements added for preventive breast implant explantation to reduce remote risk of anaplastic large cell lymphoma and B cell lymphoma. Effective 11/1/2022. Policy clarified. Indications for explantation of saline-filled implant are the same to those of silicone-filled implant (i.e., infection, extrusion, Baker class IV contracture, or surgical treatment of breast cancer).
6/2022	Prior authorization information clarified for PPO plans. Effective 6/1/2022.
1/2022	Clarified prior authorization information.
1/2021	Clarified coding information.
10/2020	Clarified coding information.
1/2020	Policy clarified to include that 130 to 150 cc implant equates to a one-cup-size increase.
11/2017	Policy updated with literature review through November 17, 2017. Reference list updated. Policy statements unchanged.
9/2016	Breast Reconstruction after Mastectomy statements transferred from retired policy 459. 9/1/2016
7/2016	New medically necessary indications described. Effective 7/1/2016.
10/2015	Clarified coding information.
9/2015	Clarified coding information. Updated reconstruction criteria and age requirements. Effective 9/1/2015.
11/2014	Clarified language transferred from medical policy #068, Plastic Surgery.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

1. Allergan. Biocell Product Safety Alert. 2019. <https://www.biocellinformation.com/>. Accessed June 1, 2022.
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Endnotes

¹ Based on expert opinion

² The Women's Health and Cancer Rights Act of 1998 (WHCRA) is federal legislation that provides that any individual, with insurance coverage who is receiving benefits in connection with a mastectomy covered by their benefit plan (whether or not for cancer) who elects breast reconstruction, must receive coverage for the reconstructive services as provided by WHCRA. This includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of the mastectomy including lymphedemas.