MEDICAL MUTUAL®

Medical Policy

Policy:	**94002**	**Effective Date:**	**12/01/2023**
SUBJECT:	**Breast Reconstruction and Related Procedures** **- Nipple Tattooing** **- Mastopexy** **- Breast Implant Removal** **- Breast Implant Insertion and/or Replacement** **- Breast Reconstruction Surgery** **- Breast Periprosthetic Capsulectomy** **- Breast Periprosthetic Capsulotomy**	**Annual Review Date:** **Last Revised Date:**	**10/10/2023** **03/14/2024**

Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.

Some or all procedure codes listed in this Corporate Medical Policy may be considered experimental/investigational.

Definition: Breast reconstruction and related procedures such as nipple tattooing, mastopexy, breast implant insertion and breast reconstruction surgery are performed to re-establish the normal appearance of a breast following a medically necessary mastectomy, medical condition, injury or congenital abnormality.

Potential complications of breast implants include implant rupture and capsular contracture. Surgical interventions, such as implant removal, periprosthetic capsulotomy or periprosthetic capsulectomy may be required to address implant rupture or capsular contracture.

Breast reconstruction and related procedures performed to alter or enhance the aesthetic appearance of the breast in the absence of a medically necessary mastectomy, medical condition, injury or congenital abnormality is considered cosmetic.

Medical Necessity:

I. Nipple tattooing: The Company considers nipple tattooing **medically necessary** and eligible for reimbursement providing that ***at least one*** of the following medical criteria is met:

- Malignant neoplasm of breast or nipple; or
- Personal history of malignant neoplasm of breast or nipple; or
- Congenital or traumatic absence and/or deformity of nipple-areolar complex.

II. Mastopexy: The Company considers **medically necessary** and eligible for reimbursement providing that ***at least one*** of the following clinical conditions is present:

- Malignant neoplasm of female breast

- Malignant neoplasm of male breast
- Personal history of malignant neoplasm of breast

III. Breast implant removal: The Company considers removal of a silicone gel-filled or saline breast implant(s) **medically necessary** and eligible for reimbursement providing that ***at least one*** of the following medical criteria is met:

- Malignant neoplasm of breast or nipple; or
- Inability to perform breast cancer screening, evaluation or mammography due to severe periprosthetic contracture or presence of breast implant. Documentation must demonstrate limitation of mammography for screening and evaluation for breast cancer; or
- Implant associated with Baker Class IV† contracture. Documentation must include photographs, pathology report(s) or abnormal imaging study (i.e., ultrasound, mammogram, magnetic resonance imaging). Photographs must demonstrate breast distortion or severe capsular contracture. Ultrasonography, mammography or magnetic resonance imaging must demonstrate a calcified or severely thickened capsule; or
- Recurrent or severe periprosthetic infection of a breast; or
- Extrusion of implant through the skin; or
- Rupture of silicone gel-filled implant. Ultrasonography, mammography or magnetic resonance imaging must demonstrate clear evidence of implant rupture; or
- Confirmed diagnosis of implant-associated anaplastic large cell lymphoma; or
- Members with textured implants that have been withdrawn from the market at the request of the FDA (Allergan BIOCELL).

NOTE: If a criterion is met for ipsilateral breast implant removal, the Company considers removal of a contralateral implant **medically necessary** and eligible for reimbursement *providing both implants are removed at the same time*.

NOTE: Breast periprosthetic capsulectomy: The Company considers breast periprosthetic capsulectomy **medically necessary** and eligible for reimbursement providing that ***all*** medical criteria listed above for breast implant removal (III) are met.

Capsulectomy is ***not*** indicated for a leaking or deflated saline implant in the absence of severe capsular contracture or calcification.

IV. Breast implant insertion and/or replacement: The Company considers breast implant insertion and/or replacement **medically necessary** and eligible for reimbursement providing that ***at least one*** of the following medical criteria is met:

- Breast reconstruction (immediate or delayed) following subcutaneous, partial or total mastectomy for breast cancer; or

- Breast reconstruction (immediate or delayed) following mastectomy for prevention of breast cancer; or
- Replacement of temporary tissue expander with permanent implant when the original procedure was performed as a result of neoplasm, infection, burn, trauma or significant congenital anomaly.

NOTE: The Company considers breast implantation **cosmetic** and **not medically necessary** if the criteria outlined in this Corporate Medical Policy are not met.

V. Breast reconstruction surgery: The Company considers breast reconstruction surgery **medically necessary** and eligible for reimbursement providing that ***at least one*** of the following medical criteria is met:

- Mastectomy, lumpectomy or other breast surgery for treatment of breast cancer. Breast reconstruction surgery includes both cancerous and contralateral breasts (to achieve symmetry); or
- Unilateral or bilateral prophylactic mastectomy for breast cancer; or
- Breast disfigurement due to trauma, infection, significant congenital anomaly or other non-malignant disease;

NOTE: Autologous fat grafting *without* adipose-derived stem cells: The Company considers autologous fat grafting ***without*** adipose-derived stem cells **medically necessary** and eligible for reimbursement providing that ***all*** medical criteria listed above for breast reconstruction surgery (V) are met.

All non-breast reconstruction related requests for autologous fat grafting should refer to **CMP 201929: Cosmetic Procedures**.

Based upon our findings, the Company has determined autologous fat grafting ***with*** adipose-derived stem cells has not demonstrated equivalence or superiority to currently accepted standard means of treatment. The Company considers autologous fat grafting ***with*** adipose-derived stem cells **investigational** and not eligible for reimbursement.

NOTE: Breast Reconstruction with neurotization: The Company considers breast reconstruction with neurotization **investigational** and **not** eligible for reimbursement.

NOTE: Revision of reconstructed breast due to normal aging is considered **not medically necessary** and **not** eligible for reimbursement.

NOTE: The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law detailing minimum standards and guidelines that must be provided to an individual who chooses breast reconstruction procedure in connection with a mastectomy. If mastectomy is a covered benefit under the member's health plan, plan certificate or summary plan description, the Company considers surgery and reconstruction of the contralateral

(non-diseased) breast following a mastectomy **medically necessary** and eligible for reimbursement and will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed; and
- Surgery and reconstruction of the contralateral breast to produce a symmetrical appearance; and
- Prosthesis (e.g., breast implant), durable medical equipment (e.g., pneumatic compression device) and physical complications due to the mastectomy, whether or not durable medical equipment coverage benefit is present.

NOTE: Based upon the Women's Health and Cancer Rights Act of 1998 (WHCRA) not all of the above criteria may be applicable to an individual with a history of breast cancer or a history of treatment for breast cancer, including prophylactic mastectomies.

NOTE: The Company uses MCG Care Guideline A-0274 (custom) to guide coverage decisions for reduction mammaplasty (mammoplasty) not related to breast cancer.

VI. Breast periprosthetic capsulotomy: The Company considers breast periprosthetic capsulotomy for **any** reason (e.g., implant repositioning due to malposition, implant change or exchange, replacement of tissue expander) **incidental** to breast implant removal, reconstruction or revision and **not** eligible for reimbursement.

†**Baker Classification**

Class I	Augmented breast feels soft as a normal breast.
Class II	Augmented breast is less soft and implant can be palpated, but is not visible.
Class III	Augmented breast is firm, implant is palpable and the implant (or distortion) is visible.
Class IV	Augmented breast is hard, painful, cold, tender and distorted.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Prior approval is required for CPT Codes 11920, 11921, 11922, 11970, 11971, 19316, 19325, 19340, 19342, 19350, 19357, 19361, 19364, 19367, 19368, 19369 19396 and HCPCS Code L8600 when received without a valid diagnosis.

Prior approval is required for CPT Codes 19328, 19330, 19371, 19380, 19499, 15769, 15771 and applicable ICD-10-CM Procedure Codes.

CPT Codes 19499, 15769, 15771 and applicable ICD-10-CM Procedure Codes are considered investigational and not eligible for reimbursement when determined to be autologous fat grafting *with* adipose-derived stem cells to the breast.

Sources of Information:

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Applicable Code(s):	
CPT:	**11920, 11921, 11922, 11970, 11971, 19316, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 19499, 15769 and 15771**
HCPCS:	**L8600, S2066, S2067 and S2068**
ICD-10-CM Procedure:	**3E00XMZ , 0HST0ZZ, 0HSU0ZZ, 0HSV0ZZ, 0HPT0JZ, 0HPT3JZ, 0HPU0JZ, 0HPU3JZ, 0H0T0JZ, 0H0T3JZ, 0H0U0JZ, 0H0U3JZ, 0HRT07Z, 0HRT0JZ 0HRT37Z, 0HRT0KZ, 0HRU37Z, 0HRU07Z, 0HRU0JZ, 0HRU0KZ, 0HRT075 0HRU075, 0HRV075, 0KXK0Z6, 0KXK4Z6 , 0KXL0Z6, 0KXL4Z6, 0HRT0JZ, 0HCT0ZZ, 0HCT3ZZ, 0HCT7ZZ, 0HCT8ZZ, 0HCTXZZ, 0HCU0ZZ, 0HCU3ZZ, 0HCU7ZZ, 0HCU8ZZ, 0HCUXZZ, 0HBT0ZZ, 0HBT3Z, 0HBT7ZZ, 0HBT8ZZ, 0HBTXZZ, 0HBU0ZZ, 0HBU3ZZ, 0HBU7ZZ, 0HBU8ZZ, 0HBUXZZ, 0HBV0ZZ, 0HBV3ZZ, 0HBV7ZZ, 0HBV8Z and 0HBVXZZ**