

Subject: Breast Surgical Procedures**Medical Policy #:** 27.0**Status:** Reviewed**Original Effective Date:** 09/26/2018**Last Review Date:** 01-25-2023

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

Breast reconstruction after mastectomy is offered to individuals of all ages and is an integral component of therapy for patients with breast cancer or who have elected to have a medically necessary prophylactic mastectomy. Breast reconstruction is a series of surgeries done following a mastectomy, either for cancer, as a prophylactic mastectomy for cancer risk, for benign disease, or accident/trauma. Breast reconstruction following mastectomy may be immediate (at the same time as the mastectomy) or delayed. The selection of various procedure reconstruction may be based on an assessment of cancer treatment, patient body habitus, smoking history, comorbidities and patient concerns.

Definition:

Reconstructive Surgery means the following:

1. Surgery to correct a physical functional disorder resulting from a disease or congenital anomaly; following an injury or incidental to any surgery.
2. Reconstructive surgery and associated procedures following a mastectomy that resulted from malignancy, and internal breast prosthesis incidental to the surgery.

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function but may also be done to approximate a normal or symmetric appearance.

Cosmetic Surgery

Cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem is not a covered benefit.

Cosmetic surgery performed purely for the purpose of enhancing one's appearance is not eligible for coverage. Additional cosmetic surgeries, done at the same time as reconstructive procedures, are not a covered benefit.

Surgery will be considered cosmetic rather than reconstructive when there is no functional impairment present. However, some congenital, acquired, traumatic or developmental anomalies may not result in functional impairment; and can be considered case-by-case basis for reconstructive surgery.

Treatment of complications arising from cosmetic surgery will be considered reasonable and necessary as long as infection, hemorrhage or other serious documented medical complication occurs after beneficiary has been officially discharged from the facility.

Coverage Determination

Prior Authorization may be required. Some procedures require prior authorization. Logon to Pres Online to submit a request: <https://ds.phs.org/preslogin/index.jsp>

For breast surgery coverage related to gender reassignment surgery, please see MPM 7.3.

Contents: This Medical Policy includes the following items:

1. [Breast Reconstruction Following Mastectomy:](#)
2. [Breast Implant Removal and/or Replacement and Capsulectomy:](#)
3. [Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy \(Macromastia\):](#)
4. [Gigantomastia of Pregnancy:](#)
5. [Gynecomastia \(Surgical Treatment\):](#)
6. [Tattooing:](#)
7. [External Breast Prostheses:](#)
8. [Biological Implant for Tissue Reinforcement Procedure of the Breast:](#)

1. **Breast Reconstruction Following Mastectomy:**

Prior authorization is required for 11970, 11971, S2066, S2067, S2068.

Coverage is for **Medicare, Medicaid and Commercial** health plan members.

PHP follows NCD 140.2 for medically necessary mastectomy or lumpectomy that results in a significant deformity. ¹

Autologous fat transplantation (grafting): to the breast and trunk related surgery (15769, 15771, 15772) and if appropriate (19499), only for cancer breast reconstruction surgery for cancer.

2. **Breast Implant Removal and/or Replacement and Capsulectomy:**

Prior Authorization is not required.

PHP follows CMS LCD Cosmetic and Reconstructive Surgery ([L39051](#)) and related policy article ([A58774](#)) for **Medicare, Medicaid and Commercial members.**

Removal or revision of a breast implant is considered medically necessary when it is removed for one of the following reasons:

- a. Mechanical complication of breast prosthesis; including rupture or failed implant, and/or implant extrusion.
- b. Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants.
- c. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, and/or painful capsular contracture with disfigurement.

3. **Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy (Macromastia):**

Prior authorization is not required for 19318.

Note: The use of 19318 requires a secondary diagnosis as indicated in CMS LCA ([A56587](#)).

Description: Reduction mammoplasty (19318) is a surgical procedure performed to reduce the volume and weight of the breast tissue. A reduction mammoplasty is considered reconstructive surgery when there is a physiological impairment caused by symptomatic breast hypertrophy; the intent of breast reduction surgery is to resolve the symptoms and alleviate the physiological impairment.

Cosmetic surgery performed to shape normal structures of the body in order to improve the patient's appearance and self-esteem is **not** a covered benefit.

PHP follows CMS LCD Cosmetic and Reconstructive Surgery [L35090](#) and related article ([A56587](#)) for **Medicare, Medicaid and Medicaid** members.

4. **Gigantomastia of Pregnancy:**

Prior authorization is not required.

Note: The use of 19318 requires a secondary diagnosis as indicated in CMS LCA ([A56587](#)).

Description: Gestational Gigantomastia (GG) is a rare disease characterized by diffuse, extreme, and incapacitating enlargement of one or both breasts during pregnancy. Although benign, it can lead to a great social, emotional, and physical disability.

PHP follows CMS LCD ([L35090](#)) Cosmetic and Reconstructive Surgery and related article ([A56587](#)) for **Medicare, Medicaid and Commercial** members.

5. **Gynecomastia (Surgical Treatment):**

Prior Authorization is required for 19300. Please check with PHP Prior Authorization Department or the PHP website.

Logon to Pres Online to submit a request: <https://www.phs.org/providers/authorizations/Pages/default.aspx>

Description: Gynecomastia is the benign proliferation of glandular breast tissue in males. Surgical procedures commonly used to remove the glandular breast tissue include mastectomy and reduction mammoplasty. Fatty tissue alone does not meet the definition of gynecomastia.

Presbyterian follows CMS LCD [L35090](#) Cosmetic and Reconstructive Surgery and policy article ([A56587](#)), for **Medicare, Medicaid and Commercial** members.

Non-covered: Liposuction or ultrasonically assisted liposuction (15877 suction assisted lipectomy; trunk) used for the treatment of gynecomastia is considered integral to the primary procedure and not covered perLCA ([A56587](#)). See Panniculectomy and Abdominoplasty, [MPM 16.5](#).

6. **Tattooing:**

Prior Authorization is not required for 11920, 11921, 11922.

PHP follows CMS LCD Cosmetic and Reconstructive Surgery ([L39051](#)) and policy article ([A58774](#)), for **Medicare, Medicaid and Commercial members.**

Tattooing to correct color defects of the skin may be considered reconstructive when performed in connection with a post-mastectomy reconstruction.

Must be performed by an appropriately licensed professional.

Coding

The coding listed in this medical policy is for reference only. Applicable CPT for Tattoo are **11920, 11921, 11922**. For diagnosis see table titled ICD-10 for Tattooing. Secondary diagnosis related to reconstructive absence of the breast, (i.e. malignancy) must go together with the primary diagnosis ICD-10-CM code L81.8 and L81.9.

7. External Breast Prostheses:

Prior authorization is not required

PHP follows CMS LCD [L33317](#) External Breast Prostheses and related policy article ([A52478](#)), for **Medicare, Medicaid and Commercial** members. A breast prosthesis is covered for a patient who has had a mastectomy.

8. Bioengineered Skin and Soft Tissue Substitutes of the Breast:

For Medicare, Medicaid and Commercial.

Applicable procedure codes may include: 15271, 15272, 15273, 15274, 15777, 19357, 19361, 19364, 19367, 19368, 19369, 19380, Q4100, Q4116, Q4122, and Q4128.

Prior authorization is required for 15271, 15272, 15273 and 15274.

PHP will consider skin and soft tissue substitutes medically necessary for breast reconstructive surgery following mastectomy when using **ONE** of the following approved products and when **ONE** of the following indications is met:

- Additional coverage is required, due to inadequate tissue expander or implant coverage by the pectoralis major muscle, **OR**
- Postmastectomy skin flaps are at risk of dehiscence or necrosis, **OR**
- Reestablishment of inframammary and lateral mammary landmark(s) undermined during mastectomy.

Product(s):

- Alloderm
- Cortiva (formerly known as AlloMax, NeoForm)
- DermACELL
- DermaMatrix
- FlexHD

Breast reconstruction surgery using one of the products not meeting the criteria as indicated above is considered not medically necessary.

Note: The skin substitute graft codes are not to be reported for application of **non-graft wound dressings**. The non-graft wound dressings (e.g., gel, ointment, foam, liquid, powder) or injected skin substitutes (e.g. code Q4246 & Q4145) are generally included in standard wound care management; such products may provide value and, in fact, may preclude the need for skin substitute application.^{13,14}

Coding

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

CPT Codes	Reconstructive Breast Surgery LCD (L35090) or (L39051). See related policy article (A56587) or (A58774) for covered diagnoses.
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), Code first 11921
19300	Removal of breast tissue
15877	Suction assisted lipectomy (for reduction of breast tissue); trunk. Liposuction or ultrasonically assisted liposuction (15877 suction assisted lipectomy; trunk) used for the treatment of gynecomastia (19300) is considered integral to the primary procedure and not covered.
19316	Mastopexy, (Suspension of breast)
19318	Reduction of mammoplasty. Do not use 19318 for Gynecomastia. The use of 19318 requires the following secondary diagnoses: L26, L30.4, L54, L95.1, L98.2, M25.511, M25.512, M54.2, M54.6, M54.9, N62, N64.1,

CPT Codes	Reconstructive Breast Surgery LCD (L35090) or (L39051). See related policy article (A56587) or (A58774) for covered diagnoses.
	O91.211, O91.212, O91.213, R21, Z48.3 for Medicare, Medicaid and Commercial.
19325	Mammoplasty, augmentation; with prosthetic implant, (enlarge breast with implant)
19328	Removal of intact mammary implant, (removal of breast implant)
19330	Removal of implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction, (immediate breast prosthesis)
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction, (delayed breast prosthesis)
19350	Nipple/areola reconstruction, (breast reconstruction)
19355	Correct inverted nipple(s)
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
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap, single pedicle, including closure of donor site
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap, single pedicle, including closure of donor site; with microvascular anastomosis
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap, double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast, (surgery of breast capsule)
19371	Periprosthetic capsulectomy, breast, (removal of breast capsule)
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant, (design custom breast implant)

CPT	Autologous fat transplantation. The following codes are provided as a guideline for the physician and are not meant to be exclusive of other possible codes.
19499	Unlisted procedure, breast
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)

HCPCS code	External Breast Prostheses LCD (L33317). See related policy article (A52478) for covered diagnoses.
A4280	Adhesive skin support attachment for use with external breast prosthesis, EACH
L8000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type **Covered for a patient who has a covered mastectomy form (L8020) or silicone (or equal) breast prosthesis (L8030) when the pocket of the bra is used to hold the form/prosthesis.
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and Schedule of Benefits to determine coverage [MPMPCC051001].

HCPCS code	External Breast Prostheses LCD (L33317). See related policy article (A52478) for covered diagnoses.
L8010	Breast prosthesis, mastectomy sleeve
L8015	Breast prosthesis external garment, with mastectomy form, post mastectomy
L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8031	Breast prosthesis, silicone or equal, with integral adhesive (non-covered)
L8032	Nipple prosthesis, reusable, any type, each
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, EACH
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8039	Breast prosthesis

CPT Code	Other related breast surgical procedures
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
C1789	Prosthesis, breast (implantable). No separate payment will made.
L8600	Implantable breast prosthesis, silicone or equal. No separate payment made. No separate payment will made
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
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq. cm; first 25 sq. cm or less wound surface area
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq. cm; each additional 25 sq. cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1% of body area of infants and children
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq. cm; each additional 100 sq. cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
Q4116	AlloDerm, per sq cm
Q4100	Skin substitute, not otherwise specified <ul style="list-style-type: none"> • Cortiva (formerly known as AlloMax, NeoForm) • DermaMatrix
Q4122	DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cm
Q4128	FlexHD, or AllopatchHD, per sq cm
Q4145	EpiFix, injectable, 1 mg

Reviewed by / Approval Signatures

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References

- Centers for Medicare and Medicaid Services. [The Women's Health and Cancer Rights Act, Title IX](#), Sec. 173 (3). Required Coverage for Reconstructive Surgery Following Mastectomy. Accessed 12/12/2022
- CMS, [NCD for Breast Reconstruction Following Mastectomy-140.2](#), Version #1, effective date 01/01/1997. Accessed 12/12/2022.
- CMS, Cosmetic and Reconstructive Surgery, (L35090) Revision Effective 07/11/2021, R#9. Related policy, Local Coverage Article: Billing and Coding: Cosmetic and Reconstructive Surgery (A56587), Revision history date 07/11/2021, R#5. [Cited 12/12/2022].
- CGS, DME LCD (L33317), External Breast Prostheses Revision History Number 8, revision effective date: 01/01/2020; Related Policy Article, LCA A52478, External Breast Prostheses, Revision date 01/01/2020 R7. Accessed 12/08/2022.
- [US Food and Drug Administration, Medical Devices, Risks of Breast Implants, Capsular Contracture](#), Content current as of 06/13/2022. [Cited 12/12/2022].
- MCG, ACG: A-0274, 26th Edition, Reduction Mammoplasty (Mammoplasty), Last Update: 8/31/2022. Accessed 12/12/2022.
- MCG, ACG: A-0273, 26th Edition, Mastectomy for Gynecomastia, Last Update 08/31/2022. Accessed 12/12/2022
- [Aetna, Breast Reconstructive Surgery, Number 0185](#), (still covers autologous fat transplant) Last Review: 04/16/2021, Next Review: 02/10/2022. Accessed 12/21/2021.
- Hayes, Autologous Fat Grafting for Breast Reconstruction After Breast Cancer Surgery (Rating B). Published August 27, 2015. Updated Oct 21/2020. Accessed 12/21/2021.
- CMS, Wisconsin Physicians Service Insurance Corporation, Local Coverage Determination Cosmetic and Reconstructive Surgery (L34698), Retired and replaced by (L39051) Cosmetic and Reconstructive Surgery on 11/13/2021 [Cited 12/14/2021]
- CMS, Wisconsin Physicians Service Insurance Corporation, Local Coverage Determination Cosmetic and Reconstructive Surgery (L39051), Revision history Date 09/22/2021. Related companion article (A57475), revision date 01/01/2021, R2. [Cited 12/14/2021]
- [CMS, HCPCS Public Meeting Agenda for Drugs, Biologicals and Radiopharmaceuticals Thursday, May 7, 2015](#) (see Agenda item #9 for Cortiva), [Cited 12/13/2022]
- CPT Assistant, October 2017 Page: 9 Category: Frequently Asked Questions, Micronized/powdered form of human allograft applications, correct reporting. CPT® Assistant copyright 1990-2022 American Medical Association. All rights reserved. [Cited 12/21/2022]
- Novitas, Local Coverage Determination (LCD): Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L35041), Revision Date: 09/26/2019, Revision #R19. There has been no change in content to the LCD. Accessed 12/21/2022.

Publication History

- 09/26/18 Combined previous MPM's into this Policy.
MPM 2.2, Breast Implant Removal or Replacement & Capsulectomy, (Effective date: 01-27-05)
MPM 2.5, Breast Reduction Mammoplasty, (Effective date 01/1998)
MPM 2.11, Breast Reconstruction Following Mastectomy, (Effective date: 11-19-08)
MPM 7.0, Gynecomastia, (Effective date: Aug 1998)
- 07/03/19: Correction to policy to remove MCG language and updated LCD links to current version
- 11/20/19 Annual review. Updated web links to LCDs and updated CPT and ICD-10-CM codes. No substance change to policy. Tattooing now requires secondary diagnoses that is applicable to reconstructive surgery.
- 01/27/21 Annual review. Reviewed by PHP Medical Policy Committee on 01/06/2021. The following were reviewed.
- Correction to effective date: change from 05-22-2006 to 09-26-2018.
 - For Breast Reconstruction Following Mastectomy: Removed NCD 140.2 and will now follow the mandated coverage by the Women's Health and Cancer Rights Act of 1998 for all LOB.
 - Language added: *Program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.*
 - New item: Autologous fat transplantation (grafting) to the breast and trunk related surgery (15769, 15771, 15772 including lumpectomy for breast reconstruction surgery related to medically necessary breast surgery. No PA required but will set to only pay ICD-10 listed in LCA (A56587).
 - For removal/revision of a breast implant: Replaced Novitas LCD L35090 with Wisconsin LCD L34698 and removed the old criteria that has been carrying over for years from previous policies. Continue no PA for: 19328, 19330, 19370, 19371, 19380.

- For Reduction Mammoplasty (19318) for Symptomatic Breast Hypertrophy (Macromastia): Medicaid will now follow MCG A-0274, both Commercial and Medicaid will follow MCG. Medicare will resume to follow LCD L35090.
- For Reduction Mammoplasty (using CPT 19318) for macromastia and gigantomastia will now require a secondary diagnoses as indicated in LCA A56587: L26, L30.4, L54, L95.1, L98.2, M25.511, M25.512, M54.2, M54.6, M54.9, N62, N64.1, O91.211, O91.212, O91.213, R21, Z48.3 for all LOB. Language added to policy: *"The use of 19318 requires a secondary diagnosis."* Code 19318 will continue without PA requirement.
- Codes C1781, C1789 and L8600 are status indicator-N and considered bundled into procedure. These codes are set to not pay for all LOB.
- New overall codes added to policy:
 - 19499, 15769, 15771, 15772, 19301, 19302, L8033 will not require PA:
 - 15777 will be removed from PA grid and will be set to not pay, OOPS status indicator- N considers bundled into procedure.
- Continue PA for: 11920, 11921, 11922, 11970, 11971, 15877, 19300, S2066, S2067, S2068, L8032, L8035, L8039 for all LOB.
- Codes C1789, L8600 removed from policy and will be removed from PA grid and will be set to not pay as it's considered bundled to procedure. (this is an error- codes will remain in policy)
- Per LCA A56587 (R4) and A57475 (R2) as 01/01/2021, the following CPT codes 19324 and 19366 have been deleted and therefore have been removed from the articles.

01/26/22

Annual review. Reviewed by PHP Medical Policy Committee on 12-15-21, 12-17-21, 12-22-21 & 01-05-22.

1. **Breast Reconstruction following Mastectomy:** Continue to follow WHCRA of 1998 for all LOBs. Language changed from *"Autologous fat transplantation (grafting): to the breast and trunk related surgery (15769, 15771, 15772) and if appropriate (19499) including lumpectomy for breast reconstruction surgery for cancer related to medically necessary breast surgery"* to *"Autologous fat transplantation (grafting): to the breast and trunk related surgery (15769, 15771, 15772) and if appropriate (19499) only for cancer breast reconstruction surgery for related to cancer. medically necessary breast surgery"*.
 - Continue PA requirement for 11970, 11971, S2066, S2067 and S2068.
 - Update previous configuration for ICD-10 codes listed in LCA (A58774- Group 1 - plus add dx code: C50.422) to link to CPT codes (15769, 15771 and 15772) for all LOB and continue no PA requirement.
 - Continue no PA requirement for 19499. (There is an out of Jurisdiction - LCA (A57849) - Tomosynthesis-Guided Breast Biopsy).
 - Correction: Removed language that Prior Auth is required for code 15777. Continue no PA requirement and keep code 15777 as SI -N- per OPPS.
2. **For Removal/revision of a Breast Implant:** Change: On 11/13/2021- Wisconsin LCD (L34698) and LCA (A57475) both got retired and replaced by Wisconsin LCD (L39051) Cosmetic and Reconstructive Surgery and related LCA (A58774). Commercial, Medicare and Medicaid will now follow LCD (L39051) and related LCA (A58774). The criteria did not change during the LCD transition.
 - CPT Codes: 19316, 19328, 19330, 19340, 19342, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380 and 19396 will be linked to ICD-10 codes listed in LCA (A58774- Group 1) along with diagnosis (C50.422) for all LOB; and continue no PA requirement. Note: DX code (C50.422) was not included in the LCA (A58774) but the code will still be configured to follow LCA (A58774) as indicated.
 - Configuration update from last review: CPT code 19350 and 19325 configurations will be updated to link ICD-10 codes listed in LCA (A58774-Group 1) plus add diagnosis (C50.422); and keep diagnosis (F64.0, F64.1, F64.8, F64.9 and Z87.890) for all LOB; and continue no PA requirement.
3. **Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy (Macromastia):** Continue to follow LCD (L35090/A56587) for Medicare. Non-Medicare will continue to follow MCG A-0274. Continue no PA requirement for (code 19318). Configuration update from last review: CPT code 19318 configuration will be updated to link ICD-10 codes listed in both LCAs, (A58774, Group-2 & Group-3 Paragraphs) and (A56587, Group-4) for all LOB; and continue no PA requirement.
4. **Gigantomastia of Pregnancy (code 19318):** Continue to follow LCD L35090/LCA A56587 for Medicare, Medicaid and Commercial. See #3 for details on 19318.
5. **Gynecomastia:** Continue to follow LCD (L35090)/LCA (A56587) for all LOB. Continue PA requirement (19300) since the configuration has been deferred. Code (15877) applies to Panniculectomy MPM 27.0 and will not be addressed in this policy.
6. **Tattooing:** LCD (L35090) and LCA (A56587) has been removed, since the coverage information for codes (11920, 11921 and 11922) is no longer mentioned in the LCD (L35090). Policy will now follow Wisconsin new LCD (L39051) & LCA (A58774) for Medicare, Medicaid and Commercial. The criteria did not change. For all LOB, CPT codes 11920, 11921 and 11922 will be link to ICD-10 codes listed in LCA (A58774) Group 1 (not Group 4) plus ICD-10 (C50.422) will be included. PA will no longer be required for 11920 and 11921. The tattoo CPT codes will be linked to breast reconstruction ICD-10 instead of pigmentation disorder.
7. **External Breast Prostheses:** Continue to follow LCD (L33317) and LCA (A52478) for all products lines. Continue no PA requirement. Correction: Removed language that said PA is required for codes: L8032, L8035 and L8039. Nipple prosthesis HCPCS codes L8032 and L8033 is non-covered for all LOB - it

does not meet CMS coverage as DME due to the useful lifetime expectancy for a nipple prosthesis is 3 months. HCPCS code L8035 is non-covered for all LOB – it is not medically necessary.

8. **Other review and determination:**

- Continue no PA requirement for 19301 and 19302 based on claims report reviewed - these codes are billed by appropriate providers with appropriate diagnosis.
- Remove C1789 and L8600 from PA grid, since these were previously configured as Status Indicator N per OPPS. Correction to previous Publication: HCPCS codes C1789, L8600 will remain listed in the policy.

01/25/23

Annual review.

1. Breast Reconstruction following Mastectomy: Change to follow NCD (140.2) and not WHCRA of 1998 for all LOB because WHCRA is a Federal Law. The following have no change.
 - Continue coverage for the use of Autologous fat transplantation (grafting) codes (15769, 15771, and 15772 for ALOB. No update to previous configuration for ICD-10 codes listed in LCA (A58774- Group 1 - plus dx code: C50.422) to link to CPT codes (15769, 15771 and 15772) for all LOB. Continue no PA requirement for these codes
 - Continue PA requirement for 11970, 11971, S2066, S2067, and S2068
 - Continue no PA requirement for codes 19499 and 15777, (15777 still listed as SI -N- per OPPS).
2. For Removal/revision of a Breast Implant: Continue to follow WPS LCD (L39051) Cosmetic and Reconstructive Surgery and related LCA (A58774) for ALOB.
 - Continue previous config for CPT codes: 19316, 19328, 19330, 19340, 19342, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380 and 19396 to link the (108) ICD-10 codes listed in LCA (A58774-Group 1) along with diagnosis (C50.422) for all LOB; and continue no PA requirement. Note: DX (C50.422) is not listed in LCA (A58774).
 - Continue previous config for CPT codes 19350 and 19325 to link (108) ICD-10 codes listed in LCA (A58774-Group 1) plus diagnosis (C50.422); and gender dysphoria DX (F64.0, F64.1, F64.8, F64.9 and Z87.890) for all LOB; and continue no PA requirement.
3. Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy (Macromastia): Change to have all LOB follow LCD (L35090/A56587). Non-Medicare will no longer follow MCG A-0274. The coverage determination guideline language was removed from policy and reformatted to only include LCD/LCA weblinks. Continue no PA requirement for (code 19318). Continue config CPT code 19318 to link ICD-10 codes listed in both LCAs, (A58774, Group-2 & Group-3 Paragraphs) and (A56587, Group-4) for all LOB; and continue no PA requirement.
4. Gigantomastia of Pregnancy (code 19318): Continue to follow LCD L35090/LCA A56587 for Medicare, Medicaid and Commercial. The coverage determination guideline language was removed from policy and reformatted to only include LCD/LCA weblinks. See #3 for details on 19318.
5. Gynecomastia: Continue to follow LCD (L35090) and LCA (A56587) for all LOB. The coverage determination guideline language was removed from policy and reformatted to only include LCD/LCA weblinks. Continue with previous config (Jan 2022) for code 19350 (see #2 above) and continue no PA requirement.
6. Tattooing: Continue to follow Wisconsin LCD (L39051) & LCA (A58774) for Medicare, Medicaid and Commercial. For all LOB, continue previous config of codes 11920, 11921 and 11922 to link to ICD-10 codes listed in LCA (A58774) Group 1 (not Group 4) plus ICD-10 (C50.422) and continue no PA requirement.
7. External Breast Prostheses: Continue to follow LCD (L33317) and LCA (A52478) for all products lines. Continue no PA requirement. Nipple prosthesis HCPCS codes L8032 and L8033 is non-covered for all LOB - it does not meet CMS coverage as DME due to the useful lifetime expectancy for a nipple prosthesis is 3 months. HCPCS code L8035 is non-covered for all LOB – it is not medically necessary. Removal of billing guideline language. Continue CY 2021 decision to remove PA requirement for: L8032 (no utilization); L8035 (low utilization); L8039 (no utilization) and linked (58) ICD-10 codes listed in Group 3 of Cosmetic and Reconstructive Surgery LCD A56587 and (58) ICD-10 codes listed in Group 3, External Breast Prostheses LCA (A52478).
8. Biological Skin and Soft Tissue Substitutes of the Breast: New item added which includes criteria and approved products (Alloderm; Cortiva (formerly known as AlloMax, NeoForm); DermACELL; DermaMatrix; and FlexHD). Added applicable codes: 15271, 15272, 15273, 15274, Q4116, Q4100, Q4122, and Q4128
9. Other review and determination:
 - Continue no PA requirement for 19301 and 19302 based on claims report reviewed - these codes are billed by appropriate providers with appropriate diagnosis.
 - Remove C1789 and L8600 from PA grid, since these were previously configured as Status Indicator N per OPPS. Correction to previous Publication: HCPCS codes C1789, L8600 will remain listed in the policy.
 - Added code Q4145 requires PA.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and Schedule of Benefits to determine coverage [MPMPCC051001].

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: [Click here for Medical Policies](#)

Web links:

At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.