PRESBYTERIAN

Medical Policy

Subject: Breast Surgical Procedures

Medical Policy #: 27.0 **Original Effective Date:** 09/26/2018

Status: Reviewed **Last Annual Review Date:** 03/26/2025

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:

3. Breast Reduction Mammaplasty 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 Surgery:
Prior authorization is not required.

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

Breast reconstruction surgery includes prostheses and treatment of physical complications in all stages of mastectomy including lymphedema, when performed to restore and improve function and correct any deformities or abnormal structures of the body that have been caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease [3] (i.e., mastectomy or lumpectomy for treatment of or prophylaxis for breast cancer and mastectomy or lumpectomy performed for chronic, severe fibrocystic breast disease [4] also known as cystic mastitis, unresponsive to medical therapy).

A. PHP considers breast reconstruction medically necessary for either 1 or 2.

1. After medically necessary **mastectomy** for 1 or more of the following [2];
   - Reconstruction of affected breast following removal of breast for any medical reason.
   - Reconstruction of contralateral unaffected breast following removal of breast for any medical reason.

   OR

2. After medically necessary **lumpectomy** that results in a significant deformity.

B. PHP considers surgery and reconstruction of the other breast to produce a symmetrical appearance [1] for repair of breast asymmetry due to a medically necessary **mastectomy** or **lumpectomy** that results in a significant deformity. Medically necessary procedures on the non-diseased/unaffected/contralateral breast to produce a symmetrical appearance may include areolar and nipple reconstruction, areolar and nipple tattooing, augmentation mammoplasty, augmentation with implantation of FDA-approved internal breast prosthesis when the unaffected breast is smaller than the smallest available internal prosthesis, breast implant removal and subsequent re-implantation when performed to produce a symmetrical appearance, breast reduction by mammoplasty or mastopexy, capsulectomy, capsulotomy, and reconstructive surgery revisions to produce a symmetrical appearance;

C. PHP considers Autologous fat transplantation (grafting) as a replacement for implants for breast repair, or to fill defects after medically necessary breast surgery.

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 Mammaplasty 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 mammaplasty (19318) is a surgical procedure performed to reduce the volume and weight of the breast tissue. A reduction mammaplasty 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, Commercial and Medicaid** members. For additional coverage information on medically necessary diagnoses, see also LCA (A58774).

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 mammaplasty. 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 per LCA (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:**
Prior Authorization is required for 15271, 15272, 15273, 15274 and Q4145.

For Medicare, Medicaid and Commercial, 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.

The following product(s) are considered medically necessary when used in association with a covered, medically necessary breast reconstruction procedure:

- Alloderm®
- Cortiva™
- AlloMax™
- DermACELL™
- FlexHD®
- DermaMatrix™ Acellular Dermis

Exclusion to #8. Bioengineered Skin and Soft Tissue Substitutes of Breast

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

The following products are considered **unproven**, **investigational** and/or **experimental**, (not an all-inclusive list) when used in association with a covered, medically necessary breast reconstruction procedure.

- ARTIA™ Reconstructive Tissue Matrix
- Avance® Nerve Graft
- BellaDerm® Acellular Hydrated Dermis
- Biodesign® Nipple Reconstruction Cylinder
- GalaFLEX® Scaffold
- GalaFLEX 3DR Scaffold (formerly known as GalaFORM™ 3D)
- GalaFLEX 3D Scaffold (formerly known as GalaSHAPE™ 3D)
- hMatrix®
- Juvederm®
- OviTex®
- Permacol™
- Phasix™ Mesh
- Renuva® Allograft Adipose Matrix
- Repriza®
- SERI™ Surgical Scaffold
- SimpliDerm™
- Strattice™ Reconstructive Tissue Matrix
- SurgiMend®
- Veritas Collagen Matrix

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	Mastectomy for gynecomastia
15877	Suction assisted lipectomy; trunk. Liposuction or ultrasonically assisted liposuction (15877 suction assisted

CPT Codes	**Reconstructive Breast Surgery LCD (L35090) or (L39051). See related policy article (A56587) or (A58774) for covered diagnoses.**
	lipectomy; trunk) used for the treatment of gynecomastia (19300) is considered integral to the primary procedure and not covered.
19316	Mastopexy
19318	Breast reduction **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, O91.211, O91.212, O91.213, R21, Z48.3 for Medicare, Medicaid and Commercial.
19325	Breast augmentation with implant
19328	Removal of intact 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	Correct inverted nipple(s)
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
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

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
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 implant
11971	Removal of tissue expander(s) without insertion of implant
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
Q4116	AlloDerm, per square centimeter
Q4100	Skin substitute, not otherwise specified Considered Medically Necessary when used to report: • Cortiva (formerly known as AlloMax, NeoForm) • DermaMatrix Aceullular Dermis • AlloMax™
Q4122	DermACELL, per square centimeter
Q4128	FlexHD, or AllopatchHD, or matrix HD, per square centimeter
C1781	Mesh (implantable) Considered Medically Necessary when used to report the following products:

CPT Code	Other related breast surgical procedures
	• AlloMax™ • DermaMatrix Aceullular Dermis
C9399	Unclassified drugs or biologicals Considered Medically Necessary when used to report the following products: • Cortiva™ • DermaMatrix Aceullular Dermis
Q4145	EpiFix, injectable, 1 mg

Product	Codes
Considered Medically Necessary	
AlloDerm®	15777, Q4116
AlloMax™	15777, C1781, Q4100
Cortiva™ (Cortiva 1.0 mm and Cortiva 1 mm tailored allograft dermis)	15777, C9399, C1763, Q4100
Dermacell™	15777, Q4122
FlexHD®	15777, Q4128
DermaMatrix Acellular Dermis	15777, C1781, C9399, Q4100
Experimental, Investigational or Unproven and Not Medically Necessary	
ARTIA™ Reconstructive Tissue Matrix	15777, C1763
Avance® Nerve Graft	64912, 64913 C9399, Q4100
BellaDerm® Acellular Hydrated Dermis	15777, C1781, C9399, Q4100
Biodesign® Nipple Reconstruction Cylinder	19350 C1763
GalaFLEX® Scaffold	15777, C1781, C9399, Q4100
GalaFLEX 3DR Scaffold	15777, C1781, C9399 Q4100
GalaFLEX 3D Scaffold	15777, C1781, C9399, Q4100
hMatrix	15777, Q4134
Juvederm®	19350, 11950 C9399
OviTex®	15777, C1781
Permacol™	15777, C9364
Phasix™ Mesh	15777, C1781
Renuva® Allograft Adipose Matrix	No specific code CPT code, J3590
Repriza®	15777, Q4143
SERI™ Surgical Scaffold	15777, C1781, Q4100
SimpliDerm™	15777, C9399, Q4100
Strattice™ Reconstructive Tissue Matrix	15777, Q4130
SurgiMend® Collagen Matrix	15777, C9358, C9360
Veritas Collagen Matrix	15777, C9354

Code	Description:
Considered Experimental/Investigational/Unproven:	
C9354	Acellular pericardial tissue matrix of nonhuman origin (Veritas), per sq cm
C9358	Dermal substitute, native, nondenatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm
C9360	Dermal substitute, native, nondenatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm
C9364	Porcine implant, Permacol, Per sq cm
Q4130	Strattice ™, per sq cm
Q4134	HMatrix, per sq cm
Q4143	Repriza, per sq cm
Experimental/Investigational/Unproven when used to report ARTIA™ Reconstructive Tissue Matrix, BellaDerm® Acellular Hydrated Dermis, GalaFLEX® Scaffold, GalaFLEX 3DR Scaffold, GalaFLEX 3D Scaffold, Juvederm, Phasix™ Mesh, or SERI™ Surgical Scaffold:	

C1781	Mesh Implantable
C9399	Unclassified drugs or biologicals
Q4100	Skin substitute, not otherwise specified
Experimental/Investigational/Unproven when used to report Juvederm®	
C9399	Unclassified drugs or biologicals
Experimental/Investigational/Unproven when used to report Biodesign® Nipple Reconstruction Cylinder:	
C1763	Connective tissue, non-human (includes synthetic)
Considered Experimental/Investigational/Unproven when used to report ARTIA™ Reconstructive Tissue or Matrix, Biodesign® Nipple Reconstruction Cylinder:	
C1763	Connective tissue, nonhuman (includes synthetic)
Considered Experimental/Investigational/Unproven when used to report Avance® Nerve Graft and SimpliDerm™:	
C9399	Unclassified drugs or biologicals
Q4100	Skin substitute, not otherwise specified
Considered Experimental/Investigational/Unproven when used to report when used to report Phasix Mesh and OviTex®	
C1781	Mesh (implantable)
Considered Experimental/Investigational/Unproven when used to report SERI™ Surgical Scaffold:	
C1781	Mesh (implantable)
Q4100	Skin substitute, not otherwise specified

Reviewed by / Approval Signatures

Population Health & Clinical Quality Committee: Clinton White MD
Senior Medical Director: Jim Romero MD
Date Approved: 03/26/2025

References

1. 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 02/04/2025
2. CMS, NCD for Breast Reconstruction Following Mastectomy-140.2, Version #1, effective date 01/01/1997. Accessed 02/04/2025.
3. Novitas, 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 02/04/2025].
4. Wisconsin, Cosmetic and Reconstructive Surgery (L39051) Revision Effective 11/30/2023, R#2. Related policy, Local Coverage Article: Billing and Coding Cosmetic and Reconstructive Surgery, (A58774), Revision history date, 08/23/2023 R#5. [Cited 02/04/2025]
5. 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.
6. US Food and Drug Administration, Medical Devices, Risks of Breast Implants, Capsular Contracture, Content current as of 06/13/2022. [Cited 12/12/2022].
7. MCG, ACG: A-0274, 27th Edition, Reduction Mammaplasty (Mammoplasty), Last Update: 9/21/2023. Accessed 02/04/2025.
8. MCG, ACG: A-0273, 27th Edition, Mastectomy for Gynecomastia, Last Update 09-21-2023. Accessed 02/04/2025
9. Aetna, Breast Reconstructive Surgery, Number 0185, (still covers autologous fat transplant) Last Review: 2024, Next Review: 02/10/2022. Accessed 02/04/2025.
10. Hayes, Autologous Fat Grafting for Breast Reconstruction After Breast Cancer Surgery. Health Technology assessment Oct 21, 2020, Annual review: Nov 13, 2023. Accessed 02/04/2025.
11. 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 08/31/2023, R3. [Cited 02/04/2025]
12. 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 02/04/2025.
13. Novitas, Billing and Coding: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds, LCA (A54117), R21, 0813/2020. [Cited 02/04/2025]

14. CMS, Women's Health and Cancer Rights Act (WHCRA), Page Last Modified: 09/06/2023 [Cited 02/05/2025]
15. Hayes, AlloDerm® Regenerative Tissue Matrix (LifeCell Corp.) For Postmastectomy Breast Reconstruction, Health Technology AssessmentMay 13, 2009, Annual Review:May 16, 2011. Accessed 02/04/2025
16. Hayes, FlexHD Acellular Dermis (Musculoskeletal Transplant Foundation) For Breast Reconstruction, Health Technology Assessment Aug 3, 2012, Annual Review: Aug 27, 2013. Accessed 02/04/2025
17. Hayes, Human Acellular Dermal Matrix for Breast Reconstruction, Health Technology Assessment Jan 28, 2019, Annual Review: Feb 28, 2022. Accessed 02/04/2025
18. ARTIA: U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health. ARTIA Reconstructive Tissue Matrix Perforated (K162752). Feb 24, 2017. Accessed Jan 23, 2023. Available at URL address: 510(k) Premarket Notification (fda.gov). Accessed 02/04/2025
19. Hayes, Processed Nerve Allografts with the Avance Nerve Graft (Axogen Corporation) for Peripheral Nerve Discontinuities Health Technology Assessment Mar 2, 2020 | Annual Review:May 11, 2023, Accessed 02/04/2025
20. ECRI Institute. Clinical Evidence Assessment. Cortiva and Cortiva 1 mm allograft dermis (RTI Surgical, Inc.) for breast reconstruction. https://www.ecri.org. Published November 13, 2018. Updated November 30, 2020. Accessed 01/05/2024
21. Momeni A, Meyer S, Shefren K, Januszyk M. Flap Neurotization in Breast Reconstruction with Nerve Allografts: 1-year Clinical Outcomes. Plast Reconstr Surg Glob Open. 2021;9(1):e3328. Published 2021 Jan 12. doi:10.1097/GOX.0000000000003328.
22. Collins B, Williams JZ, Karu H, Hodde JP, Martin VA, Gurtner GC. Nipple Reconstruction with the Biodesign Nipple Reconstruction Cylinder: A Prospective Clinical Study. Plast Reconstr Surg Glob Open. 2016 Aug 9;4(8):e832.
23. U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health. GalaFLEX™ Mesh (K140533). May 21, 2014. Accessed 02/04/2025. Available at URL address: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm?ID=K140533
24. Williams SF, Martin DP, Moses AC. The History of GalaFLEX P4HB Scaffold. Aesthet Surg J. 2016 Nov;36(suppl 2):S33-S42. Accessed 02/04/2025
25. Bacterin International Holdings Inc., Belgrade, MT. hMatrix®. 2015. Accessed 02/04/2025. Available at URL address: http://xtantmedical.com/app/uploads/2016/09/hMatrix-PR-ADM-Brochure_5258D_Digital.pdf
26. U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health. Juvederm® Voluma XC (P110033). October 22, 2013. Accessed 02/04/2025. Available at URL address: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P110033
27. TelaBio® Inc. OviTex® Reinforced Tissue Matrix. 2022. Accessed 02/04/2025. Available at URL address: https://www.telabio.com/ovitex.html#science
28. U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health. Phasix™ Mesh (K142818). March 31, 2015. Accessed 02/04/2025. Available at URL address: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm?ID=K142818
29. Bard Davol, Inc. Phasix™ Mesh. 2022. Accessed 02/04/2025. Available at URL address: BD Hernia Repair Mesh and Fixation | BD
30. MTF Biologics. Renuva® Allograft Adipose Matrix Instructions for Use. 2020. Accessed 02/04/2025. Available at URL address: https://www.mtfbiologics.org/docs/default-source/packageinserts/2020/pi-113- rev-8.pdf
31. Fine NA, Lehfeldt M, Gross JE, Downey S, Kind GM, Duda G, et al. SERI surgical scaffold, prospective clinical trial of a silk-derived biological scaffold in two-stage breast reconstruction: 1-year data. Plast Reconstr Surg. 2015 Feb;135(2):339-51.
32. Hayes, SimpliDerm Acellular Dermal Matrix (Elutia), **Clinical Research Response***Dec 8, 2023.* Accessed 02/04/2025
33. Baker BG, Irri R, MacCallum V, Chattopadhyay R, Murphy J, Harvey JR. A Prospective Comparison of Short-Term Outcomes of Subpectoral and Prepectoral Strattice-Based Immediate Breast Reconstruction.
34. Ball JF, Sheena Y, Tarek Saleh DM, Forouhi P, Benyon SL, Irwin MS, Malata CM. A direct comparison of porcine (Strattice™) and bovine (Surgimend™) acellular dermal matrices in implant-based immediate breast reconstruction. J Plast Reconstr Aesthet Surg. 2017 Aug;70(8):1076-1082.
35. Plast Reconstr Surg. 2018 May;141(5):1077-1084.Hayes, SurgiMend (Integra Life Sciences) For Postmastectomy Breast Reconstruction, Health Technology Assessment, Apr 27, 2017 Annual Review: May 2, 2019. Accessed 02/04/2025
36. Borgognone A, Anniboletti T, De Vita F. Does Veritas® play a role in breast reconstruction? a case report. Breast Cancer (Dove Med Press). 2011 Dec 20;3:175-7. doi: 10.2147/BCTT.S27954. eCollection 2011. Accessed 02/04/2025

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 Mammaplasty (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 Mammaplasty (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, S2067and 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 Mammaplasty 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 Mammaplasty 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 (46) ICD-10 codes listed in Group 1, 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.

Updated on 09-27-2023: Reviewed by PHP Medical Policy Committee on 08/30/2023. Update configuration in Health Rules Payer (HRP) to map ICD-10 to CPT code 19318, using Novitas LCA (A56587-Group 4) and WPS LCA (A58774- Group 2 & Group 3) and continue no PA requirement for ALOB.

02/07/24

1. **Breast Reconstruction Surgery**: Change to follow NCD (140.2) and WHCRA of 1998 for all LOB. The following changed.
   - Title changed from "*Breast reconstruction Following Mastectomy*" to *Breast Reconstruction Surgery*."
   - Added clarifying language from WHCRA, such as, breast reconstruction surgery includes prostheses and treatment of physical complications in all stages of mastectomy including lymphedema; surgery and reconstruction of the other breast to produce a symmetrical appearance; and included examples on the type of disease such as fibrocystic breast.
   - Removed language that Autologous fat transplantation (grafting) is only for cancer related breast reconstruction and replaced it with "Autologous fat transplantation (grafting) as a replacement for implants for breast repair, or to fill defects after medically necessary breast surgery." 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.
   - Removed PA requirement for tissue expander codes (11970 and 11971), since the primary surgical codes do not require PA.
   - Removed PA requirement for S2066, S2067, and S2068. Rationale: Diagnosis are appropriate and denial rate is low. Also, because the primary procedures do not require PA.
   - Continue no PA requirement for codes 19499 and 15777, (15777 still listed as SI -N- per OPPS).
2. **Breast Implant Removal and/or Replacement and Capsulectomy**: No change. 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) & (Q79.8) for all LOB; and continue no PA requirement. Note: DX (C50.422) is not listed in LCA (A58774).
   - Continue previous config for CPT codes 19325 and 19350 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 Mammaplasty for Symptomatic Breast Hypertrophy (Macromastia**): No change. Continue to follow LCD (L35090/A56587 and/or A58774) for ALOB. 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): No change. Continue to follow LCD L35090/LCA A56587 for Medicare, Medicaid and Commercial. See #3 for details on config of 19318.
5. **Gynecomastia:** No change. Continue to follow LCD (L35090) and LCA (A56587) for all LOB. Continue with previous config (Jan 2022) for code 19350 (see #2 above) and continue no PA requirement. Continue PA requirement for 19300.
6. **Tattooing**: No change. Continue to follow Wisconsin LCD (L39051) & LCA (A58774) for Medicare, Medicaid and Commercial. For all LOB, continue previous config to Link CPT codes 11920, 11921 and 11922 to DX code (C50.422) and (108) ICD-10 codes listed in LCA (A58774) - Group 1 (not the (3) ICD-10 pigmentation disorder (L81.8, L81.9, and Z42.8) listed in Group-4) and continue to not require PA.
7. **External Breast Prostheses:** No change. 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. Continue CY 2021 configuration to link HCPCS codes: L8032 (no utilization); L8035 (low utilization); L8039 (no utilization) to (58) ICD-10 codes listed in Group 3 of Cosmetic and Reconstructive Surgery LCA (A56587) and (46) ICD-10 codes listed in Group 1, External Breast Prostheses LCA (A52478) and continue not to require PA.
8. **Biological Skin and Soft Tissue Substitutes of the Breast**: The following products will continue to be considered medically necessary when used in association with medically necessary breast reconstruction: (Alloderm; Cortiva (formerly known as AlloMax, NeoForm); DermACELL; DermaMatrix: and FlexHD).
   - Change: Added the following skin substitute products names to the policy that are considered unproven, investigational and/or experimental (not an all-inclusive list) when used in association

with a covered, medically necessary breast reconstruction procedure: ARTIA; Avance® Nerve Graft; BellaDerm® Acellular Hydrated Dermis; Biodesign® Nipple Reconstruction Cylinder; GalaFLEX® Scaffold; GalaFLEX 3DR Scaffold (formerly known as GalaFORM™ 3D) ; GalaFLEX 3D Scaffold (formerly known as GalaSHAPE™ 3D), hMatrix®; Juvederm®; OviTex®, Permacol™, Phasix™ Mesh; Renuva® Allograft Adipose Matrix, Repriza®; SERI™ Surgical Scaffold; SimpliDerm™; Strattice™ Reconstructive Tissue Matrix, SurgiMend®; and Veritas Collagen Matrix.

- Removed listing of CPT codes in the body of criteria. Updated the description in the table of CPT codes for: 19300, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 11970, 11971, Q4116, Q4100, Q4122, Q4128.
- Removed the following codes: 15271, 15272, 15273, and 15274 since these codes are topical application of skin substitute rather than an implantation of biologic implant (15777).
- Update the PA grid: Remove PA requirement specific to "MPM 27.0" on the PA grid for codes (15271, 15272, 15273, and 15274).
- Skin Substitutes codes specific to the product name that will be configured as experimental are: Q4130, Q4134, Q4143, C9358, C9360, C9354, and C9364.

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.
    - Continue previously configured codes C1789 and L8600 since they are considered bundled (Status Indicator N) per OPPS.

03-26-2025 Annual Review. MPC Met on 2/5/2025, 2/7/2025 and 2/14/2025. Policy to continue as listed in 2024 without change. Current information has been reviewed for configurations and has not found any updates necessary. Continue PA on 19300 and skin substitute application codes, 15271, 15272, 15273, 15274 and Q4145. Continue CY 2021 and CY 2024 configuration for all other services, ALOB.

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.

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.