MEDICAL POLICY	**Breast Surgery: Reduction Mammoplasty, Reconstructive Surgery, and Implant Management (Medicare Only)**
Effective Date: 7/1/2022  7/1/2022 Medical Officer Date	Medical Policy Number: 523 Medical Policy Committee Approved Date: 3/2022; 6/2022

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

Notes:

- This policy does not apply to the treatment of male gynecomastia (CPT 19300), which is addressed in the *Cosmetic and Reconstructive Surgery (Medicare Only)* medical policy.
- This policy does not address breast reconstructive procedures when included in the treatment of gender dysphoria, which is addressed in the *Gender Affirming Surgical Interventions* policy.
- The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Breast Reconstruction Surgery ***Following Mastectomy*** Includes: • Any breast reconstructive surgical procedure, including but not limited to, a	National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2) **NOTE:** This NCD is not limited to any specific breast reconstruction procedure. Therefore, this NCD will apply to any part of the breast reconstructive process, including but not limited to a mammoplasty when performed following a mastectomy (includes complete mastectomy or partial

reduction mammoplasty following a mastectomy	mastectomy [lumpectomy]) if rendered for any medical reason (i.e., accidental injury, trauma, breast cancer, etc.). This applies to both the affected and contralateral unaffected breast.
*Breast Reconstruction Surgery **Not** Following a Mastectomy or Breast Surgery Procedures Performed for Any Other Indication (e.g., cosmetic surgeries)* Includes: • Removal of breast implants • Reduction mammoplasty • Breast augmentation performed for the purpose of enhancing appearance	Local Coverage Determination (LCD) for Plastic Surgery (L37020) *See "Policy Guidelines" below*
Use of Skin Substitutes in the above Procedures	Skin substitutes used in breast reconstruction or surgical procedures may be considered **medically necessary** when both of the following are met: 1. The skin/tissue substitute has been approved for use in breast reconstruction procedures, and 2. The above NCD or LCD criteria for the breast surgery itself are met.

POLICY GUIDELINES

Cosmetic Surgery

According to the Medicare Benefit Policy Manual, Chapter 16, §120:

> "Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose."

Therefore, under *Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)(4)*, cosmetic procedures or services are excluded from Medicare coverage:

> "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member."

Reconstructive Surgery

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. While it is generally performed to improve function, it may also be done to approximate a normal appearance. *(Noridian LCD L37020)*

Medicare Coverage

In order to determine if coverage is available for a procedure, review may be required to determine if the procedure is cosmetic or reconstructive in nature.

BILLING GUIDELINES

See associated local coverage articles (LCAs) for related billing and coding guidance:

- LCA: Billing and Coding: Plastic Surgery (A57222)

Free Flap Breast Reconstruction

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[1], indicates HCPCS codes S2066-S2068 have been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." HCPCS codes S2066-S2068 are not covered for Medicare Plan members unless allowed under a Medicare Advantage provider contract exception, as indicated in the relevant Company coding policy *(Coding Policy 22.0 HCPCS S-Codes and H-Codes)*.

According to CPT Guidelines, "Code 19364 describes a microsurgical free tissue transfer of skin and subcutaneous fat and/or muscle for breast reconstruction. This code includes the flap harvest, microsurgical anastomosis of one artery and two veins with use of an operating microscope, flap inset as a breast mound, and donor-site closure. Typical free flaps include free transverse rectus abdominis myocutaneous (fTRAM), deep inferior epigastric perforator (DIEP), superficial inferior epigastric artery (SIEA), or gluteal artery perforator (GAP) flaps." Therefore, CPT code 19364 is the appropriate code to use, rather than HCPCS codes S2066-S2068.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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)
19316	Mastopexy
19318	Breast reduction
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	Correction of inverted nipples
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 (eg, fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
No Prior Authorization Required	
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

MEDICAL POLICY CROSS REFERENCES

- Cosmetic and Reconstructive Procedures (Medicare Only), MP232
- Skin and Tissue Substitutes, MP16
- Surgical Treatments for Lymphedema, MP222

REFERENCES

1. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files