Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Breast Reconstruction Services

Policy Number: PG0144
Last Review: 05/01/2024

GUIDELINES:

- **This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.**
- **Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.**
- **This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.**

SCOPE:

X Professional
_Facility

DESCRIPTION:

Reconstructive breast surgery is a surgical procedure that is designed to restore the normal appearance of a breast after a medically necessary mastectomy for breast cancer or other medical condition, injury or congenital abnormality, or unilateral hypertrophy resulting in symptoms following contralateral mastectomy. In contrast, cosmetic breast surgery is defined as surgery designed to alter or enhance the appearance of a breast that has not undergone a medically necessary surgery, an accidental injury/trauma, congenital defect, infection, or other non-malignant disease.

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

Breast reconstruction is considered medically necessary to create a simulated breast, specifically attempting to match the performance of a normal breast (regardless of gender). Breast reconstruction surgery rebuilds a breast's shape following a mastectomy or trauma and may be performed immediately, be delayed, or be completed in stages. The surgery usually necessitates two stages; the first stage is for the reconstruction of the breast; the second stage is for reconstruction of the nipple and areola. Breast reconstruction is designed to reduce post-mastectomy complications and to establish symmetry between the surgical breast and the contralateral breast.

The following procedures may be utilized during breast reconstruction:

- A woman’s own muscle, fat and skin are repositioned to create a breast mound by one of the following methods:
  - Transverse Rectus Abdominus Myocutaneous (TRAM) Flap – The muscle, fat and skin from the lower abdomen is used to reconstruct the breast
  - Deep Inferior Epigastric Perforator (DIEP) or Superior Gluteal Artery Perforator (SGAP) Flap – The fat and skin but not muscle is used from the lower abdomen or buttocks to reconstruct the breast
  - Latissimus Dorsi (LD) Flap – The muscle, fat and skin from the back are used to reconstruct the breast – may also need a breast implant
  - Other methods may also be used to move muscle, fat, and skin to reconstruct a breast

- Tissue expansion is used to stretch the skin and tissue to provide coverage for a breast implant to create a breast mound. The procedure can be done with or without a dermal matrix including but not limited to Alloderm, Allomax, DermACELL, or FlexHD. Note: Reconstruction alone may be done with an implant, but a tissue expander may be needed.
- After the tissue expansion is completed, surgical placement of an FDA approved breast implant; (either silicone or saline) is performed. The breast implant may be used with a flap or alone following tissue expansion.
- After the breast implant is completed, creation of a nipple (by various techniques) and areola (tattooing) may be performed.
- Mastopexy or breast reduction when required prior to mastectomy to preserve the viability of the nipple.

Surgical procedures that are performed to establish symmetry can include, breast reduction, breast augmentation with an FDA-approved breast implant, and/or areola-with-nipple reconstruction and nipple-area tattooing. Breast reconstruction after mastectomy has evolved over the last century to become an integral component of therapy for patients with breast cancer. The breast can be reconstructed in conjunction with mastectomy using breast implants, autologous tissue (i.e., flaps, harvested abdominal fat), or a combination of the two (e.g., latissimus/implant composite reconstructions).

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

- **Breast Reconstruction Services do not require prior authorization if reported with the pre-selected cancer diagnoses as listed below.**
- **Prior authorization is required for all other indications.**
- **Intraoperative assessment of tissue perfusion by any technology including, but not limited to the Spy Elite System (C9733, 76499) (near-infrared angiography with indocyanine green) does not warrant separate reimbursement.**

The specific medical indications in which Paramount will allow breast reconstruction services are enumerated in the following table and do not require a prior authorization if done within the Paramount Provider Network:

Breast Reconstructive Services that will be reimbursed WITHOUT PRIOR AUTHORIZATION	
The predetermined cancer diagnosis must be reported in the *first position* on the claim form.	
PROCEDURE CODE	**DIAGNOSIS CODE**
19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 15769, 15771 **Supplemental Services 11920, 11921, 11922, 11970, 11971, L8600**	C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.129, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.621, C50.622, C50.811, C50.812, C50.821, C50.822, C79.81, D05.01, D05.02, D05.10, D05.11, D05.12, D05.81, D05.82, D48.62, Z85.3 The following diagnoses were added to specifically allow facility claims to process the cancer related facility claims: V45.71, V51.0, 611.81, 611.83, 611.89, 612.0, 612.1, 996.54 and 996.79 (ICD-10-CM CODE; EFFECTIVE 10/01/2015: N64.81, N65.0, N65.1, T85.41xA, T85.42xA, T85.43xA, T85.44xA, T85.49xA, T85.81xA, T85.82xA, T85.83xA, T85.84xA, T85.85xA, T85.86xA, T85.89xA, T86.848, T86.849, Z42.1, Z90.11, Z90.12, Z90.13). Effective 07/01/2024 removed “unspecified” diagnosis codes; C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.911, C50.912,

	C50.919, C50.921, C50.922, C50.929, D05.00, D05.80, D05.90, D05.91, D05.92, D48.60, N64.81, N64.89, Z90.10

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Breast Reconstruction after a diagnosis of breast cancer:

In compliance with the Women's Health and Cancer Right's Act of 1998, Paramount covers a breast reconstruction procedure on the affected breast and contralateral breast, all stages of reconstruction surgery, under the following circumstances:

- When performed as a breast reconstruction procedure following or in connection with a medically necessary mastectomy, subcutaneous mastectomy, and segmental or radical mastectomy. Breast reconstruction may occur at the same time as the surgery to treat the breast cancer (immediate reconstruction/neoplastic breast reconstruction) or at a later time (delayed breast reconstruction).
- Breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast.
- In connection with breast cancer, evaluation of breast cancer or suspected breast cancer.
- Reconstruction for prophylactic bilateral mastectomy in BRAC positive individuals (Reference PG0251 Prophylactic Mastectomy).

Breast Reconstruction for a diagnosis other than breast cancer:

Breast reconstruction may also be considered medically indicated for the following listing, is not inclusive of all situations eligible for reimbursement: Documentation must support a disease process or congenital abnormality where the surgical breast reconstruction will restore bodily function or correction of the deformity resulting from disease, trauma, or complication of previous surgery.

- Breast disfigurement due to trauma, infection, significant congenital anomaly, or other non-malignant disease.
- Poland's Syndrome is a rare condition in which breast reconstruction may be considered medically necessary. The chest wall repair is the primary underlying treatment. If there is no chest wall involvement the breast reconstruction related to this syndrome remains denied as cosmetic.
- Agenesis or severe hypoplasia with breast asymmetry resulting in a deformity of 50% or greater in contralateral breast,
- Scoliosis,
- Breast damaged by infection, traumatic loss, scarring, burns or X-ray therapy.

Supplemental Breast Reconstructive Services

Some breast reconstruction requires extensive efforts. Additional services may be required to improve the outcome for the patient. These services follow the same diagnosis guidelines and will be considered cosmetic if the appropriate medical diagnosis is not reported.

Surgery on the contralateral breast is covered to produce a symmetrical appearance and restoring a sense of "wholeness" to the individual. These surgical procedures may include reduction mammoplasty (reduction of the size of the breast), mastopexy (correction of the drooping breast) or implant mammoplasty (augmentation).

During some reconstructions, a patient may require multiple surgical sessions in which tissue expanders may be utilized to improve the outcome. Replacement of tissue expander with permanent implant (11970) and removal of tissue expander without insertion of implant (11971) may be required and supported by the medically indicated diagnoses.

The breast can be reconstructed in conjunction with mastectomy using breast implants, autologous tissue (i.e., flaps, harvested abdominal fat), or a combination of the two (e.g., latissimus/implant composite reconstructions).

Nipple tattooing services are considered medically necessary and eligible for reimbursement provided that at least one of the following medical criteria is met:

- Malignant neoplasm of the breast or nipple

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

Without one of the medically indicated diagnoses above, this service will always be denied cosmetic for all members.

Mastopexy is considered medically necessary and eligible for reimbursement provided that that at least one of the following clinical conditions is present:

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

Without one of the medically indicated diagnoses above, this service will always be denied cosmetic for all members.

Autologous fat grafting, autologous fat transplant (i.e., lipoinjection or lipomodeling) via excision lipectomy, suction lipectomy or liposuction when performed in conjunction to the breast has been proposed for indications that include breast augmentation and following oncologic surgery. Proposed indications after oncologic surgery include as an adjunct to reconstruction post mastectomy or lumpectomy for contour deformities and improved shape and volume of the breast, for post mastectomy pain syndrome (neuropathic pain), and for irradiated skin to soften the skin and restore it to no irradiated appearance and consistency which may reduce complications and failure rates and oncologic concerns have limited application in the breast:

- Autologous fat grafting without adopose-dervided stem cells is considered medically necessary and eligible for reimbursement when all the medical criteria listed above for breast reconstruction surgery is met.
- Autologous fat grafting with adipose-derived stem cells has not demonstrated equivalence or superiority to currently accepted standard means of treatment and is considered **investigational** and not eligible for reimbursement. (Procedures 19380, 19499, 15769, 15771 non-covered when determined to be autologous fat grafting with adipose-derived stem cells to the breast)

Breast Implant Removal

Initially inserted for Breast Cancer Reconstruction

The surgical removal of a breast implant is considered medically necessary when ALL of the following criterial is met:

- The breast implant insertion was related to breast cancer treatment or breast cancer reconstruction; and
- The treating provider has determined that removal of the member's breast implant is needed to facilitate breast cancer treatment or to treat a medical condition which may include but is not limited to ANY of the following,
    - A medical complication of a breast implant (e.g., implant rupture, infection, contracture, extrusion); or
    - Treatment of monitoring of breast cancer; or
    - Treatment related to breast reconstruction for breast cancer; and
- When criteria are met unilaterally (in the affected breast) for removal of a breast implant and the implant was inserted for breast reconstruction related to breast cancer treatment or breast cancer reconstruction, removal of the breast implant in the contralateral unaffected breast is also covered

Removal of a breast implant and capsulectomy is covered, regardless of the indication for the initial implant placement, for:

- Implants with recurrent or severe infection; or
- Extruded implants; or
- Baker Class III contractures (if initial implant was for reconstructive purposes); or
- Baker Class IV contracture, associated with severe pain; or
- Breast Cancer, new or recurrent; or
- Silicone implant rupture
- Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL)

- Suspected BIA-ALCL (symptoms of pain, swelling, redness or lump in area of implant)
- B-cell lymphoma associated with implant capsule
- Implants or tissue expanders that have been withdrawn from the market at the request of the FDA (i.e., Allergan BIOCELL®)
- If a criterion is met for ipsilateral breast implant removal, then removal of a contralateral implant is considered medically necessary and eligible for reimbursement providing both implants are removed at the same time.

Removal of breast implant for the following indications is considered not medically necessary and non-covered:
- Pain not related to contractures or rupture
- Baker Class III contractures in members with implants for cosmetic purposes
- Removal of a ruptured saline breast implant(s) when the original insertion was for cosmetic purposes
- Systemic symptoms, attributed to connective tissue disease, autoimmune diseases, etc.

Breast implant insertion and/or replacement is medically necessary and eligible for reimbursement providing that as least one of the following medical criteria are met:
- Only if the original placement surgery would have been a covered benefit (e.g., if original prosthesis were placed due to cancer surgery, replacement of the prosthesis is a covered benefit; if original surgical indication was cosmetic augmentation, replacement of the prosthesis is not a covered benefit); or
- Breast reconstruction (immediate or delayed) following subcutaneous, partial, or total mastectomy for breast cancer; or
- Breast reconstruction (immediate or delayed) following mastectomy for prevention of breast cancer; or
- Replacement of temporary tissue expander with permanent implant when the original procedure was performed as a result of neoplasm, infection, burn, trauma, or significant congenital anomaly.

Exclusions, not an all-inclusive listing:
- Breast augmentation or reconstruction that does not meet the above criteria is considered a cosmetic procedure, and therefore is not a covered benefit.
- Breast reconstruction does not include cosmetic breast augmentation surgery (augmentation mammoplasty).
- The following breast reconstruction procedures are NOT covered because such treatment is considered experimental/investigational:
    - autologous fat transplant with the use of adipose-derived stem cells
    - vascularized lymph node transfer (VLNTx)
    - xenograft cartilage grafting
    - A body lift perforator flap technique for breast reconstruction is considered experimental and investigational because there is insufficient evidence to support the effectiveness of this approach.
- The following products are not covered when used in association with a breast reconstruction procedure because they are considered experimental/investigational (this list may not be all-inclusive):
    - ARTIA™ Reconstructive Tissue Matrix
    - Avance® Nerve Graft
    - BellaDerm® Acellular Hydrated Dermis
    - Biodesign® Nipple Reconstruction Cylinder
    - DermaMatrix Acellular Dermis
    - DuraSorb® Monofilament Mesh/ Polydioxanone Surgical Scaffold™
    - GalaFLEX® Scaffold
    - GalaFLEX 3DR Scaffold (formerly known as GalaFORM™ 3D)
    - GalaFLEX 3D Scaffold (formerly known as GalaSHAPE™ 3D)
    - Juvederm®
    - OviTex®
    - Permacol™
    - Phasix™ Mesh
    - Radiesse®

    - Renuva® Allograft Adipose Matrix
    - SERI™ Surgical Scaffold
    - SimpliDerm™
    - Strattice™ Reconstructive Tissue Matrix
    - SurgiMend®
    - Veritas Collagen Matrix
- Suction lipectomy or ultrasonically assisted suction lipectomy (liposuction) for correction of surgically induced donor site asymmetry (e.g., trunk or extremity) that results from one or more flap breast reconstruction procedures is not covered because such treatment is considered cosmetic in nature and is not medically necessary.
- Nipple inversion correction is not considered medically necessary (unless the procedure is included in breast reconstruction for breast cancer treatment in the affected and/or contralateral breast)
- Following planned reconstruction of the affected breast, if the unaffected breast is already symmetrical with the affected breast after reconstruction, exchange of a non-ruptured silicone breast implant for a saline or gel implant is not covered.
- Revisions being performed for cosmetic indications following the original reconstructive surgery are not covered in the absence of clinical complications such as lymphedema, hematoma, cellulitis or other infections, significant skin, or flap necrosis. Non-covered indications include but are not limited to the following:
    - Nipple fading
    - Loss of symmetry, including tissue atrophy, after the initial symmetry has been achieved.
    - Desire for altered size
    - Biodesign Nipple Reconstruction Cylinder is considered experimental and investigational because its effectiveness has not been established.
    - Breast reconstruction procedures performed in association with a surgical repair of a chest wall deformity for Poland syndrome, pectus excavatum, or pectus carinatum, because each is considered cosmetic in nature and not medically necessary.

Additional Breast Reconstructive Services

- Intraoperative assessment of tissue perfusion by any technology including, but not limited to the Spy Elite System (C9733, 76499) (near-infrared angiography with indocyanine green) is considered integral to the primary procedure and not separately reimbursable.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
11920	Intradermal tattooing; 6sq cm or less
11921	Intradermal tattooing; 6.1 to 20sq cm
11922	Intradermal tattooing; each additional 20sq cm or part thereof
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
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, 50cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50cc injectate, or part thereof (list separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk (for reduction of breast tissue)
19316	Mastopexy
19318	Breast Reduction
19325	Breast augmentation with implant

19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansions(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction with free flap (e.g., 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 (TRM) 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
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss Procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss Procedure), with thoracoscopy
76499	Unlisted diagnostic radiographic procedure
HCPCS CODES	
C9733	Non-ophthalmic fluorescent vascular angiography
L8600	Implantable breast prosthesis, silicone or equal
ICD-10-CM CODES; EFFECTIVE 10/01/2015	
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
~~**C50.019**~~	~~Malignant neoplasm of nipple and areola, unspecified female breast~~ [removed 07/01/2024]
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
~~**C50.029**~~	~~Malignant neoplasm of nipple and areola, unspecified male breast~~ [removed 07/01/2024]
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
~~**C50.119**~~	~~Malignant neoplasm of central portion of unspecified female breast~~ [removed 07/01/2024]
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
~~**C50.129**~~	~~Malignant neoplasm of central portion of unspecified male breast~~ [removed 07/01/2024]
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
~~**C50.219**~~	~~Malignant neoplasm of upper-inner quadrant of unspecified female breast~~[removed 07/01/2024]
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
~~**C50.229**~~	~~Malignant neoplasm of upper-inner quadrant of unspecified male breast~~ [removed 07/01/2024]
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
~~**C50.319**~~	~~Malignant neoplasm of lower-inner quadrant of unspecified female breast~~ [removed 07/01/2024]

C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
~~**C50.329**~~	~~Malignant neoplasm of lower-inner quadrant of unspecified male breast~~ [removed 07/01/2024]
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
~~**C50.419**~~	~~Malignant neoplasm of upper-outer quadrant of unspecified female breast~~[removed 07/01/2024]
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
~~**C50.429**~~	~~Malignant neoplasm of upper-outer quadrant of unspecified male breast~~ [removed 07/01/2024]
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
~~**C50.519**~~	~~Malignant neoplasm of lower-outer quadrant of unspecified female breast~~ [removed 07/01/2024]
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
~~**C50.529**~~	~~Malignant neoplasm of lower-outer quadrant of unspecified male breast~~ [removed 07/01/2024]
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
~~**C50.619**~~	~~Malignant neoplasm of axillary tail of unspecified female breast~~ [removed 07/01/2024]
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
~~**C50.629**~~	~~Malignant neoplasm of axillary tail of unspecified male breast~~ [removed 07/01/2024]
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
~~**C50.819**~~	~~Malignant neoplasm of overlapping sites of unspecified female breast~~ [removed 07/01/2024]
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
~~**C50.829**~~	~~Malignant neoplasm of overlapping sites of unspecified male breast~~ [removed 07/01/2024]
~~**C50.911**~~	~~Malignant neoplasm of unspecified site of right female breast~~ [removed 07/01/2024]
~~**C50.912**~~	~~Malignant neoplasm of unspecified site of left female breast~~ [removed 07/01/2024]
~~**C50.919**~~	~~Malignant neoplasm of unspecified site of unspecified female breast~~ [removed 07/01/2024]
~~**C50.921**~~	~~Malignant neoplasm of unspecified site of right male breast~~ [removed 07/01/2024]
~~**C50.922**~~	~~Malignant neoplasm of unspecified site of left male breast~~ [removed 07/01/2024]
~~**C50.929**~~	~~Malignant neoplasm of unspecified site of unspecified male breast~~ [removed 07/01/2024]
C79.81	Secondary malignant neoplasm of breast
D05.00	~~Lobular carcinoma in situ of unspecified breast~~ [removed 07/01/2024]
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
~~**D05.80**~~	~~Other specified type of carcinoma in situ of unspecified breast~~ [removed 07/01/2024]
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
~~**D05.90**~~	~~Unspecified type of carcinoma in situ of unspecified breast~~ [removed 07/01/2024]
~~**D05.91**~~	~~Unspecified type of carcinoma in situ of right breast~~ [removed 07/01/2024]
~~**D05.92**~~	~~Unspecified type of carcinoma in situ of left breast~~ [removed 07/01/2024]
D24.1	Benign neoplasm of right breast
D24.2	Benign neoplasm of left breast
~~**D48.60**~~	~~Neoplasm of uncertain behavior of unspecified breast~~ [removed 07/01/2024]
D48.61	Neoplasm of uncertain behavior of right breast
D48.62	Neoplasm of uncertain behavior of left breast

~~**N64.81**~~	~~Ptosis of breast~~ [removed 07/01/2024]
~~**N64.89**~~	~~Other specified disorders of breast~~ [removed 07/01/2024]
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
T85.41xA	Breakdown (mechanical) of breast prosthesis and implant, initial encounter
T85.42xA	Displacement of breast prosthesis and implant, initial encounter
T85.43xA	Leakage of breast prosthesis and implant, initial encounter
T85.44xA	Capsular contracture of breast implant, initial encounter
T85.49xA	Other mechanical complication of breast prosthesis and implant, initial encounter
T85.79XA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
T85.81xA	Embolism due to internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T85.82xA	Fibrosis due to internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T85.83xA	Hemorrhage due to internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T85.84xA	Pain due to internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T85.85xA	Stenosis due to internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T85.86xA	Thrombosis due to internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T85.89xA	Other specified complication of internal prosthetic devices, implants, and grafts, not elsewhere classified, initial encounter
T86.848	Other complications of corneal transplant
T86.849	Unspecified complication of corneal transplant
Z40.01	Encounter for prophylactic removal of breast
Z42.1	Encounter for breast reconstruction following mastectomy
Z45.811	Encounter for adjustment or removal of right breast implant
Z45.812	Encounter for adjustment or removal of left breast implant
Z85.3	Personal history of malignant neoplasm of breast
~~**Z90.10**~~	~~Acquired absence of unspecified breast and nipple~~
Z90.11	Acquired absence of right breast and nipple
Z90.12	Acquired absence of left breast and nipple
Z90.13	Acquired absence of bilateral breasts and nipples

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 04/30/2008

Date	Explanation & Changes
08/01/09	• Updated verbiage
12/10/13	• Policy revised so only pertains to Breast Reconstruction • Removed ICD-9 procedure codes 85.31, 85.32, 85.50, 85.51, 85.52, 85.53, 85.54, 85.6, 85.70, 85.71, 85.72, 85.73, 85.79, 85.84, 85.85, 85.86, 85.87, 85.89, 85.93, 85.95, 85.96 • ICD-10 Codes added from ICD-9 conversion • Policy reviewed and updated to reflect most current clinical evidence. Approved by Medical Policy Steering Committee as revised
06/18/15	• Added codes C9733 & 76499 • Policy reviewed and updated to reflect most current clinical evidence per TAWG
02/26/16	• Removed code 11960. Codes S2066, S2067, and S2068 are now covered without prior authorization for HMO, PPO, & Individual Marketplace

	• 11922 is now covered for all product lines • Policy reviewed and updated to reflect most current clinical evidence per TAWG
08/13/20	• Policy Updated r/t Autologous Fat Grafting coverage during Breast Reconstructions • Autologous fat grafting without adopose-dervided stem cells is considered medically necessary and eligible for reimbursement when all the medical criteria listed above for breast reconstruction surgery is met. • Autologous fat grafting with adipose-derived stem cells has not demonstrated equivalence or superiority to currently accepted standard means of treatment and is considered investigational and not eligible for reimbursement. (Procedures 19380, 19499, 15769, 15771 non-covered when determined to be autologous fat grafting with adipose-derived stem cells to the breast)
12/15/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/9/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
03/30/2023	• Medical Policy updated to reflect DME limits calculated by CMS criteria/guidelines.
02/20/2024	• Medical Policy placed on the updated 2024 medical policy format • Effective 04/01/2024: Removed procedure codes S2066, S2067 and S2068 as they are no longer covered under the Paramount Commercial Insurance Plans, which follow the CMS coding guidelines
05/01/2024	• Medical Policy reviewed and updated to reflect the most current clinical evidence • Removed deleted codes 19324 and 19366 • Removed "Unspecified" ICD-10 diagnosis codes C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, D05.80, D05.90, D05.91, D05.92, D48.60, N64.81, N64.89, Z90.10, effective July 1, 2024 • Added ICD-10 diagnosis codes D24.1, D24.2, T85.579XA, Z45.811, Z45.812

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review

Medical Policy Prior to 05/01/2024:

Paramount Commercial Insurance Plans, Medicare Advantage Plans, and Paramount Advantage Medicaid
Breast Reconstruction Services do not require prior authorization if reported with the pre-selected cancer diagnoses as listed below.
Prior authorization is required for all other indications.

Procedures S2066, S2067, and S2068 are non-covered for Medicare Advantage Plans and Paramount Advantage Medicaid

Intraoperative assessment of tissue perfusion by any technology including, but not limited to the Spy Elite System (C9733, 76499) (near-infrared angiography with indocyanine green) does not warrant separate reimbursement.

Breast Reconstructive Services that will be reimbursed WITHOUT PRIOR AUTHORIZATION	
The predetermined cancer diagnosis must be reported in the *first position* on the claim form.	
19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 15769, 15771 **Supplemental Services 11920,**	C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.60, D48.61, D48.62, Z85.3 The following diagnoses were added to specifically allow facility claims to process the cancer related facility claims: V45.71, V51.0, 611.81, 611.83, 611.89, 612.0, 612.1, 996.54 and 996.79

11921, 11922, 11970, 11971, L8600 **<u>Paramount Commercial Plans only</u>** **S2066, S2067, S2068**	(ICD-10-CM CODE; EFFECTIVE 10/01/2015: N64.81, N64.89, N65.0, N65.1, T85.41xA, T85.42xA, T85.43xA, T85.44xA, T85.49xA, T85.81xA, T85.82xA, T85.83xA, T85.84xA, T85.85xA, T85.86xA, T85.89xA, T86.848, T86.849, Z42.1, Z90.10, Z90.11, Z90.12, Z90.13).

COVERAGE CRITERIA:

<u>Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans</u>

Breast Reconstruction after a diagnosis of breast cancer:
In compliance with the Women's Health and Cancer Right's Act of 1998, Paramount covers a breast reconstruction procedure on the affected breast and contralateral breast, all stages of reconstruction surgery, under the following circumstances:

- When performed as a breast reconstruction procedure following or in connection with mastectomy, subcutaneous mastectomy, and segmental or radical mastectomy. Breast reconstruction may occur at the same time as the surgery to treat the breast cancer (immediate reconstruction/neoplastic breast reconstruction) or at a later time (delayed breast reconstruction).
- Breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast.
- In connection with breast cancer, evaluation of breast cancer or suspected breast cancer.
- Reconstruction for prophylactic bilateral mastectomy in BRAC positive individuals (Reference PG0251 Prophylactic Mastectomy).

Breast Reconstruction for a diagnosis other than breast cancer:
Breast reconstruction may also be considered medically indicated for the following listing, is not inclusive of all situations eligible for reimbursement: Documentation must support a disease process or congenital abnormality where the surgical breast reconstruction will restore bodily function or correction of the deformity resulting from disease, trauma, or complication of previous surgery.

- Poland's Syndrome is a very rare condition in which breast reconstruction may be considered medically necessary. The chest wall repair is the primary underlying treatment. If there is no chest wall involvement the breast reconstruction related to this syndrome remains denied as cosmetic.
- Agenesis or severe hypoplasia with breast asymmetry resulting in a deformity of 50% or greater in contralateral breast,
- Scoliosis,
- Breast damaged by infection, traumatic loss, scarring, burns or X-ray therapy.

Supplemental Breast Reconstructive Services
Some breast reconstruction requires extensive efforts. Additional services may be required to improve the outcome for the patient. These services follow the same diagnosis guidelines and will be considered cosmetic if the appropriate medical diagnosis is not reported.

Surgery on the contralateral breast is covered to produce a symmetrical appearance and restoring a sense of "wholeness" to the individual. These surgical procedures may include reduction mammoplasty (reduction of the size of the breast), mastopexy (correction of the drooping breast) or implant mammoplasty (augmentation).

During some reconstructions, a patient may require multiple surgical sessions in which tissue expanders may be utilized to improve the outcome. Procedures 11970 and 11971 may be required and supported by the medically

indicated diagnoses.

The breast can be reconstructed in conjunction with mastectomy using breast implants, autologous tissue (i.e., flaps, harvested abdominal fat), or a combination of the two (e.g., latissimus/implant composite reconstructions).

Tattoo services can include the tattooing required for the nipple reconstruction. Procedures 11920, 11921 and 11922 are considered covered with certain medical diagnoses as listed above. Without these diagnoses, these services will always be denied cosmetic for all members.

Autologous fat grafting, autologous fat transplant (i.e., lipoinjection or lipomodeling) via excision lipectomy, suction lipectomy or liposuction when performed in conjunction to the breast has been proposed for indications that include breast augmentation and following oncologic surgery. Proposed indications after oncologic surgery include as an adjunct to reconstruction post mastectomy or lumpectomy for contour deformities and improved shape and volume of the breast, for post mastectomy pain syndrome (neuropathic pain), and for irradiated skin to soften the skin and restore it to no irradiated appearance and consistency which may reduce complications and failure rates and oncologic concerns have limited application in the breast:

- Autologous fat grafting **without** adopose-dervided stem cells is considered medically necessary and eligible for reimbursement when all the medical criteria listed above for breast reconstruction surgery is met.
- Autologous fat grafting **with** adipose-derived stem cells has not demonstrated equivalence or superiority to currently accepted standard means of treatment and is considered investigational and not eligible for reimbursement. (Procedures 19380, 19499, 15769, 15771 non-covered when determined to be autologous fat grafting with adipose-derived stem cells to the breast)

Breast Implant Removal

Initially inserted for Breast Cancer Reconstruction

The surgical removal of a breast implant is considered medically necessary when ALL of the following criterial is met:

- The breast implant insertion was related to breast cancer treatment or breast cancer reconstruction; and
- The treating provider has determined that removal of the member's breast implant is needed to facilitate breast cancer treatment or to treat a medical condition which may include but is not limited to ANY of the following,
    - A medical complication of a breast implant (e.g., implant rupture, infection, contracture, extrusion); or
    - Treatment of monitoring of breast cancer; or
    - Treatment related to breast reconstruction for breast cancer; and
- When criteria are met unilaterally (in the affected breast) for removal of a breast implant and the implant was inserted for breast reconstruction related to breast cancer treatment or breast cancer reconstruction, removal of the breast implant in the contralateral unaffected breast is also covered

Removal of a breast implant and capsulectomy is covered, regardless of the indication for the initial implant placement, for:

- Implants with recurrent infection; or
- Extruded implants; or
- Baker Class III or IV Contracture, associated with severe pain; or
- Breast Cancer, new or recurrent; or
- Treatment of Anaplastic Lymphoma of the breast when there is pathologic confirmation of the diagnosis by cytology or biopsy; or
- Individuals with an increased risk of implant-associated Anaplastic Lymphoma of the breast due to use of Allergan BIOCELL textured breast implants and tissue expanders; or
- Implant rupture

Replacement/reinsertion of a breast implant is a covered benefit only if the original placement surgery would have been a covered benefit (e.g., if original prosthesis were placed due to cancer surgery, replacement of the

prosthesis is a covered benefit; if original surgical indication was cosmetic augmentation, replacement of the prosthesis is not a covered benefit).

Exclusions

1. Breast augmentation or reconstruction that does not meet the above criteria is considered a cosmetic procedure, and therefore is not a covered benefit.
2. Breast reconstruction does not include cosmetic breast augmentation surgery (augmentation mammoplasty).
3. The following breast reconstruction procedures are NOT covered because such treatment is considered experimental, investigational, or unproven for this indication:
    a. autologous fat transplant with the use of adipose-derived stem cells
    b. vascularized lymph node transfer (VLNTx)
    c. xenograft cartilage grafting
    d. A body lift perforator flap technique for breast reconstruction is considered experimental and investigational because there is insufficient evidence to support the effectiveness of this approach.
4. The following products are not covered when used in association with a breast reconstruction procedure because they are considered experimental, investigational, or unproven (this list may not be all-inclusive):
    a. ARTIA™ Reconstructive Tissue Matrix
    b. BellaDerm® Acellular Hydrated Dermis
    c. Biodesign® Nipple Reconstruction Cylinder
    d. DermaMatrix Acellular Dermis
    e. GalaFLEX® Surgical Scaffold
    f. GalaFORM™ 3D
    g. hMatrix®
    h. Juvederm®
    i. Permacol®
    j. Phasix™ Mesh
    k. Radiesse®
    l. Repriza®
    m. SERI™ Surgical Scaffold
    n. Veritas Collagen Matrix
5. Suction lipectomy or ultrasonically assisted suction lipectomy (liposuction) for correction of surgically induced donor site asymmetry (e.g., trunk or extremity) that results from one or more flap breast reconstruction procedures is not covered because such treatment is considered cosmetic in nature and is not medically necessary.
6. Nipple inversion correction is not considered medically necessary (unless the procedure is included in breast reconstruction for breast cancer treatment in the affected and/or contralateral breast)
7. Following planned reconstruction of the affected breast, if the unaffected breast is already symmetrical with the affected breast after reconstruction, exchange of a non-ruptured silicone breast implant for a saline or gel implant is not covered.
8. Revisions being performed for cosmetic indications following the original reconstructive surgery are not covered in the absence of clinical complications such as lymphedema, hematoma, cellulitis or other infections, significant skin, or flap necrosis. Non-covered indications include but are not limited to the following:
    a. Nipple fading
    b. Loss of symmetry, including tissue atrophy, after the initial symmetry has been achieved.
    c. Desire for altered size
9. Biodesign Nipple Reconstruction Cylinder is considered experimental and investigational because its effectiveness has not been established.
10. Breast reconstruction procedures performed in association with a surgical repair of a chest wall deformity for Poland syndrome, pectus excavatum, or pectus carinatum, because each is considered cosmetic in nature and not medically necessary.

Additional Breast Reconstructive Services

- Procedure 19366 will be appropriately reimbursed when medical criteria and guidelines have been met.
- Intraoperative assessment of tissue perfusion by any technology including, but not limited to the Spy Elite

System (C9733, 76499) (near-infrared angiography with indocyanine green) is considered integral to the primary procedure and not separately reimbursable.