Breast Reconstruction Following Mastectomy or Lumpectomy

[For the list of services and procedures that need preauthorization, please refer to www.mcs.com.pr. Go to "Comunicados a Proveedores", and click "Cartas Circulares".]

Medical Policy:	**MP-SU-02-10**
Original Effective Date:	**March 25, 2010**
Revised:	**August 27, 2024**
Next Revision:	**August, 2025**

This policy applies to products subscribed by the following corporations, MCS Life Insurance Company (Commercial), and MCS Advantage, Inc. (Classicare) and Medical Card System, Inc., provider's contract; unless specific contract limitations, exclusions or exceptions apply. Please refer to the member's benefit certification language for benefit availability. Managed care guidelines related to referral authorization, and precertification of inpatient hospitalization, home health, home infusion and hospice services apply subject to the aforementioned exceptions.

All medical policies are developed taking into consideration the Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

DESCRIPTION

For the purposes of this medical policy, reconstructive breast surgery refers to surgery performed to individuals who underwent mastectomy or lumpectomy to correct or repair abnormal structures of the breast.

Breast reconstruction is often considered after mastectomy to correct deformity or reestablish symmetry caused by previous surgery and/or the effects of therapeutic treatments.

Reconstruction procedures may involve multiple techniques and stages to recreate the breast mound using prosthetic implants, tissue flaps, or autologous tissue transfers, as well as nipple/areola reconstruction or tattooing and breast reduction. These procedures can be performed immediately after a mastectomy (one stage breast reconstruction) or be delayed for weeks or years until a patient undergoes radiation, chemotherapy, or determines whether they want breast reconstruction (two-stage reconstruction).

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate member certificate and subscriber agreement contract for applicable diagnostic imaging, DME, laboratory, machine tests, benefits, and coverage.

INDICATIONS

Note$_1$: Breast Reconstruction services of the **affected and the contralateral unaffected** breast following a mastectomy or lumpectomy are considered **medically necessary** for all stages of reconstruction of the breast on which the mastectomy or lumpectomy has been performed; when surgery and reconstruction of the other breast is to produce a symmetrical appearance; and for prostheses and physical complications of all stages of mastectomy or lumpectomy, including lymphedema.

For clarification purposes, in this medical policy, breast reconstruction will be considered medically necessary and covered after a lumpectomy only when the lumpectomy was performed for a diagnosis of breast cancer.

I. **Medical Card System, Inc. (MCS**) will consider as **medically necessary breast reconstruction services of the affected breast** after a mastectomy performed for any medical reason or lumpectomy performed for a diagnosis of breast cancer. **Medically necessary** procedures include:
    a. Tissue/muscle reconstruction procedures (flaps);
        - transverse rectus abdominus myocutaneous (TRAM) flap;
        - latissimus dorsi (LD) myocutaneous flap;
        - deep inferior epigastric perforator (DIEP) flap;
        - superficial inferior epigastric perforator (SIEP) flap;
        - superior or inferior gluteal free flap;
        - Ruben's flap;
        - transverse upper gracilis (TUG) flap; and
        - Thoracodorsal artery perforator (TDAP) flap.
        - PAP flaps - This flap is based off the profunda femoris artery and vein that has several associated perforators within the posterior compartment of the thigh.
        - LTP flaps - The lateral thigh perforator (LTP) flap is another option for patients who have had mastectomy and are interested in autologous reconstruction.
        - LAP flaps - The lumbar artery perforator (LAP) flap is another microvascular option for patients who desire autologous breast reconstruction.
    b. Capsulotomy[i]
    c. Capsulectomy[ii]
    d. Implantation of tissue expander
    e. Implantation of U.S. FDA-approved internal breast prosthesis
    f. Areolar and nipple reconstruction
    g. Areolar and nipple tattooing
    h. Reconstructive surgical revisions
    i. Removal or revision of a breast implant is considered medically necessary when it is removed for one of the following reasons:
        - Mechanical complication of breast prosthesis; including rupture or failed implant, implant extrusion;
        - Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants;
        - Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, painful capsular contracture with disfigurement.

II. **Medical Card system, Inc., (MCS)** will consider as **medically necessary breast reconstruction services of the unaffected/contralateral breast**, in order to produce a symmetrical appearance after a mastectomy performed for any medical reason or lumpectomy performed for a diagnosis of breast cancer. **Medically necessary** procedures include:

a. Breast reduction by mammoplasty or mastopexy[iii]
b. Augmentation mammoplasty
c. Augmentation with implantation of FDA-approved internal breast prosthesis when the unaffected breast is smaller than the smallest available internal prosthesis
d. Areolar and nipple reconstruction
e. Areolar and nipple tattooing
f. Reconstructive surgery revisions to produce a symmetrical appearance
g. Breast implant removal and subsequent reimplantation when performed to produce a symmetrical appearance
h. Capsulotomy
i. Capsulectomy

III. Medical Card System, Inc., (MCS) will consider as **medically necessary** the following products when used in association with a covered / medically necessary breast reconstruction procedure:

a. AlloDerm®
b. Cortiva® (previously marketed as AlloMax™)

IV. Medical Card System, Inc., (MCS) considers the following products as **Experimental, Investigational or Unproven,** and therefore **will not** be covered:

a. DermaMatrix® Acellular Dermis
b. Permacol®
c. Radiesse®
d. Repriza™
e. SimpliDerm™
f. Strattice™ reconstructive tissue matrix
g. DermACELL™
h. FlexHD® Acellular Hydrated Dermis

Note$_2$: Medical Card System, Inc. (MCS) will consider any other product not mentioned in this medical policy as **Experimental**, **Investigational or Unproven,** and therefore non-covered, until a thorough evaluation and determination is made final by the MCS Medical Advisory Committee (MAC), and/or a new statement from a Local Coverage Determination (LCD) arises.

RATIONALE

MCS framework is designed to improve access, outcomes, and our enrollee's experience of care and to ensure all enrollees achieve their best health. This policy acts as a guideline for nursing staff in the initial screening of service requests, meticulously upholding a hierarchy that prioritizes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) established by the Centers for Medicare & Medicaid Services (CMS), followed by our organization's medical policy, recognized medical association guidelines, and clinical decision-making processes. It is crafted to ensure that preliminary

assessments are in harmony with these layers of guidance, underscoring that all final coverage determinations strictly adhere to the relevant LCDs and NCDs, while also considering the insights from recognized medical associations and the clinical judgment of healthcare professionals (MD's and DMD's) as necessary.

CODING INFORMATION

CPT® Codes (List may not be all inclusive)

CPT® Codes	DESCRIPTION
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)
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
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)
+15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)
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 (ie, 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 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

Current Procedural Terminology (CPT®) 2024 American Medical Association: Chicago, IL.

HCPCS CODES (List may not be all inclusive)

HCPCS Codes	Description
C1781	Mesh (implantable)
C1789	Prosthesis, breast (implantable)
C9358	Dermal substitute, native, nondenatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeter
C9364	Porcine Implant, Permacol, per square centimeter
L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8031	Breast prosthesis, silicone or equal, with integral adhesive
L8032	Nipple prosthesis, prefabricated, reusable, any type, each
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8039	Breast prosthesis, not otherwise specified

L8600	Implantable breast prosthesis, silicone or equal
Q4100	Skin substitute, not otherwise specified
Q4116	Alloderm, per square centimeter
Q4122	Dermacell, Dermacell AWM or dermacell AWM Porous, per square centimeter
Q4128	Flex HD, Allopatch HD, per square centimeter
Q4130	Strattice™, per sq cm
Q4134	HMatrix, per sq cm
Q4143	Repriza, per sq cm
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

2024 HCPCS LEVEL II Professional Edition® (American Medical Association).

ICD-10 Codes (List may not be all inclusive)

ICD-10-Codes	DESCRIPTION
C44.501	Unspecified malignant neoplasm of skin of breast
C44.511	Basal cell carcinoma of skin of breast
C44.521	Squamous cell carcinoma of skin of breast
C44.591	Other specified malignant neoplasm of skin of breast
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast

C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C79.2	Secondary malignant neoplasm of the skin
C79.81	Secondary malignant neoplasm of breast
D04.5	Carcinoma in situ of skin of trunk
D05.01	Lobular carcinoma in situ of right breast
D05.02	Lobular carcinoma in situ of left breast
D05.11	Intraductal carcinoma in situ of right breast

D05.12	Intraductal carcinoma in situ of left breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast
D24.1	Benign neoplasm of right breast
D24.2	Benign neoplasm of left breast
D48.61	Neoplasm of uncertain behavior of right breast
D48.62	Neoplasm of uncertain behavior of left breast
N60.01	Solitary cyst of right breast
N60.02	Solitary cyst of left breast
N60.11	Diffuse cystic mastopathy of right breast
N60.12	Diffuse cystic mastopathy of left breast
N60.21	Fibroadenosis of right breast
N60.22	Fibroadenosis of left breast
N60.31	Fibrosclerosis of right breast
N60.32	Fibrosclerosis of left breast
N60.41	Mammary duct ectasia of right breast
N60.42	Mammary duct ectasia of left breast
N60.81	Other benign mammary dysplasias of right breast
N60.82	Other benign mammary dysplasias of left breast
N60.91	Unspecified benign mammary dysplasia of right breast
N60.92	Unspecified benign mammary dysplasia of left breast
N62	Hypertrophy of breast
N64.81	Ptosis of breast
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
T85.41XA	Breakdown (mechanical) of breast prosthesis and implant, initial encounter
T85.41XD	Breakdown (mechanical) of breast prosthesis and implant, subsequent encounter
T85.41XS	Breakdown (mechanical) of breast prosthesis and implant, sequela
T85.42XA	Displacement of breast prosthesis and implant, initial encounter
T85.42XD	Displacement of breast prosthesis and implant, subsequent encounter
T85.42XS	Displacement of breast prosthesis and implant, sequela

T85.43XA	Leakage of breast prosthesis and implant, initial encounter
T85.43XD	Leakage of breast prosthesis and implant, subsequent encounter
T85.43XS	Leakage of breast prosthesis and implant, sequela
T85.44XA	Capsular contracture of breast implant, initial encounter
T85.44XD	Capsular contracture of breast implant, subsequent encounter
T85.44XS	Capsular contracture of breast implant, sequela
T85.49XA	Other mechanical complication of breast prosthesis and implant, initial encounter
T85.49XD	Other mechanical complication of breast prosthesis and implant, subsequent encounter
T85.49XS	Other mechanical complication of breast prosthesis and implant, sequela
T85.79XA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
T85.79XD	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, subsequent encounter
T85.79XS	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, sequela
T85.818A	Embolism due to other internal prosthetic devices, implants and grafts, initial encounter
T85.828A	Fibrosis due to other internal prosthetic devices, implants and grafts, initial encounter
T85.838A	Hemorrhage due to other internal prosthetic devices, implants and grafts, initial encounter
T85.848A	Pain due to other internal prosthetic devices, implants and grafts, initial encounter
T85.858A	Stenosis due to other internal prosthetic devices, implants and grafts, initial encounter
T85.868A	Thrombosis due to other internal prosthetic devices, implants and grafts, initial encounter
T85.898A	Other specified complication of other internal prosthetic devices, implants and grafts, initial encounter
Z15.01	Genetic susceptibility to malignant neoplasm of breast
Z42.1	Encounter for breast reconstruction following mastectomy
Z44.31	Encounter for fitting and adjustment of external right breast prosthesis
Z44.32	Encounter for fitting and adjustment of external left breast prosthesis
Z45.811	Encounter for adjustment or removal of right breast implant
Z45.812	Encounter for adjustment or removal of left breast implant
Z48.3	Aftercare following surgery for neoplasm
Z80.3	Family history of malignant neoplasm of breast
Z85.3	Personal history of malignant neoplasm of breast

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
Z98.82	Breast implant status

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POLICY HISTORY

DATE	ACTION	COMMENT
March 11, 2010	**Origination of Policy**	
March 24, 2011	**Yearly Review**	**1. HCPCS Codes added to the policy L8020-L8039** **2. CPT Codes added to the policy 19396**
March 9, 2012	**Yearly Review**	
March 19, 2013	**Revised**	**References updated.** Added new References, numbers 1, 2, & 7. **To the Indications Section:** Revised previous indication: Breast implant removal and subsequent reimplantation; and substituted with: Removal or revision of a breast implant is considered medically necessary when it is removed for one of the following reasons: Mechanical complication of breast prosthesis; including rupture or failed implant, implant extrusion; Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants; Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, painful capsular contracture with disfigurement. **To the Coding Information:** added the new CPT Code 19355, and the new ICD-9 Codes 173.50 – 173.52, 175.9, 217, 232.5, 610.0 – 610.9, 996.54, 996.69, 996.79 & V51.8.
March 27, 2014	**Revised**	**Annual review, no changes to coverage.** **References updated.** **To the Indication Section:** ➢ New Medical products were added in the Subsection III (b) and Subsection IV (e). ➢ Medical product "NeoForm Dermis "was retired as suggested by The Medical Advisory Committee MAC. ➢ Note#2 was added to the Medical policy to clarify the Word "Lumpectomy" that was including in the Title as suggested in the Medical Advisory Committee MAC at October 14, 2014. ➢ Autologous Fat Transplant was retired from this medical policy as suggested by the MAC for be considered experimental at this time. ➢ Note#3 was added to the medical policy to facilitate the process to determine when a new product will be approved by the MCS medical team. **To the Coding section:** ➢ New HCPCS codes were added to the policy: C9358, Q4116, Q4100, Q4110, C9364, Q4130, C9358, and C9360. ➢ A new ICD-10 Codes (Preview Draft) section was added to the policy. **To the References section:** ➢ New References (#7, 9, 10, and 11) were added to the Policy.
October 14, 2014		This medical policy was present for MAC approval on October 14, 2014. To the Indications Section: ➢ Section I was restructured to read as: "Medical Card System, Inc.

		(MCS) will consider medically necessary Breast Reconstruction services of the affected breast after a mastectomy performed for any medical reason or lumpectomy performed for a diagnosis of breast cancer. Medically necessary procedures include". ➢ Section II was restructured to read as: "Medical Card system, Inc., (MCS) will consider medically necessary Breast Reconstruction services of the unaffected/contra-lateral breast, in order to produce a symmetrical appearance after a mastectomy performed for any medical reason or lumpectomy performed for a diagnosis of breast cancer. Medically necessary procedures include:" ➢ A new Statement was added to the Medical Policy as suggested for the Medical Advisory Committee MAC on October 14, 2014: "For clarification purposes, in this medical policy, breast reconstruction will be considered medically necessary and cover after a lumpectomy only when the lumpectomy was performed for a diagnosis of breast cancer". ➢ In section III Medical Product "NeoForm™ Dermis" was retired from this medical policy after MAC determination on October 14, 2014. ➢ In section IV "Autologous Fat Graft" was removed from this medical policy after MAC determination on October 14, 2014. ➢ The new products suggested as part of the revision of March 2014, will not be included as per MAC determination on October 14, 2014, except for Repriza, that has a clear statement of not coverage from Medicare. ➢ A new note was added to the Medical Policy as suggested for the Medical Advisory Committee MAC on October 14, 2014: Note2: Medical Card System, Inc. (MCS) will consider an Experimental, Investigational or Unproven coverage for any other product not mentioned in this medical policy, until a thorough evaluation and determination is made final by the MCS Medical Advisory Committee (MAC), and/or a new statement from a Local Coverage Determination (LCD) arises.
November 23, 2015	**Revised**	**To the coding section:** • Eliminate ICD-9 codes since they are no longer valid for diagnosis classification. • Add new section of ICD-10 codes which are the valid diagnosis classification since October 1, 2015.

March 31, 2016	**Revised**	**References were updated.** **To the Coding Section:** **CPT Codes Section:** New CPT Codes were added to the Policy (+15777 and 20926) **ICD-10 Codes Section:** The following ICD-10 Codes were deleted from This Policy: C44.500, C44.510, C44.520, C50.021, C50.022, C50.029, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, T85.72XA, T86.842, T86.848, and T86.849. **ICD-10 Codes Section:** The following ICD-10 Codes were added to the Policy: C44.591, C79.2, N64.89, R92.8, Z15.01, and Z80.3. **To the References Section:** The following References were deleted from this Policy: #4 and 5. The following References were added to this Medical Policy: #9, 10, 11 and 12.
June 1, 2017	**Revised**	**To the Coding Section:** **To the ICD-10 Codes Section:** **The following ICD-10 Codes were added to the Policy:** C50.021, C50.022, C50.121, C50.122, C50.221, C50.222, C50.321, C50.322, C50.421, C50.521, C50.522, C50.621, C50.622, C50.821, C50.822, C50.921, C50.922, T85.41XD, T85.41XS, T85.42XD, T85.42XS, T85.43XD, T85.43XS, T85.44XD, T85.44XS, T85.49XD, T85.49XS, T85.79XD, T85.79XS, T85.818A, T85.818D, T85.818S, T85.828A, T85.828D, T85.828S, T85.838A, T85.838D, T85.838S, T85.848A, T85.848D, T85.848S, T85.858A, T85.858D, T85.858S, T85.868A, T85.868D, T85.868S, T85.868A, T85.868D, T85.868S, and Z42.8. **The following ICD-10 Codes were deleted from This Policy:** C44.509, C44.519, C44.529, C50.019, C50.119, C50.219, C50.319, C50.419, C50.519, C50.619, C50.819, C50.919, D05.00, D05.10, D05.80, D05.90, D24.9, N60.09, N60.19, N60.29, N60.39, N60.49, N60.89, N60.99, T85.81XA, T85.82XA, T85.83XA, T85.84XA, T85.85XA, T85.86XA, T85.89XA, Z44.30, and Z45.819. **To the References Section:** **The following References were added to this Medical Policy:** #4, 7, 9, 14, and 16. **The following References were deleted from this Policy:** #8, and 15.
December 5, 2018	**Revised**	**To the Indications Section:** **Two New Techniques were added to the Section I:** • **transverse upper gracilis (TUG) flap; and** • **Thoracodorsal artery perforator (TDAP) flap.** **To the Coding Section:** • **To the HCPCS Codes Section:** HCPCS Code Q4110 was deleted from this Policy.

		• **<u>To the ICD-10 Code Section:</u>** • **<u>The Following Codes were deleted from this Policy:</u>** R92.8, Z15.01, Z40.01, Z90.10, Z90.11, Z90.12 and Z90.13.
February 24, 2020	**Review**	**References updated. Added new #1, #4 & 15.** **To the Indications Section:** • To indication statements I, II & III: Added word "as" before medically necessary • To indication subset I-a: Added abbreviation for TRAM to transverse rectus abdominus myocutaneous flap • To indication subset III-b was modified to read: Cortiva® (previously marketed as AlloMax™) • Reworded Note 2 to read as follows: Medical Card System, Inc. (MCS) will consider any other product not mentioned in this medical policy as Experimental, Investigational or Unproven, and therefore non-covered, until a thorough evaluation and determination is made final by the MCS Medical Advisory Committee (MAC), and/or a new statement from a Local Coverage Determination (LCD) arises **To the Coding Information Section:** • Deleted CPT code 20926. • Corrected descriptor for code 15777. • Added CPT code 15769.
December 14, 2020	**Review**	**References Updated.**
December 16, 2021	**Review**	**References updated. Deleted former #2. Added new #2 & #7.** **To the Coding Information Section:** • Deleted HCPCS Code Q4130.
November 28, 2022	**Review**	**<u>To the Indications Section</u>:** • **<u>To the Section III</u>:** **<u>The following Products were added to the List</u>:** DermACELL™, and FlexHD® Acellular Hydrated Dermis. **<u>To the Coding Section</u>:** • **<u>To the CPT Code Section</u>:** **<u>The following CPT Codes were added to the Policy</u>:** 14000, 14001, 15771, and +15772. • **<u>The following CPT Codes were deleted from This Policy</u>:** 13100, 13101, and +13102. • **<u>To the HCPCS Code Section</u>:** **<u>The following HCPCS Codes were added to the Policy</u>:** C9358, C9360, Q4122, Q4128, and Q4130. • **<u>To the ICD-10 Codes Section</u>:** **<u>The following ICD-10 Codes were added to the Policy</u>:** C50.422, D48.61, D48.62, N65.0, N65.1, Z15.01, Z48.3, Z90.11, Z90.12, Z90.13, and Z98.82. **<u>To the References Section</u>:** • **<u>The following References were added to the Policy</u>:** #17. • **<u>The following References were deleted from this Policy</u>:** #14.
July 3, 2023	**Review**	**<u>To the Indications Section</u>:** **<u>New Techniques were added to the Point A</u>:** • **PAP flaps - This flap is based off the profunda femoris artery**

		and vein that has several associated perforators within the posterior compartment of the thigh. • **LTP flaps - The lateral thigh perforator (LTP) flap is another option for patients who have had mastectomy and are interested in autologous reconstruction.** • **LAP flaps - The lumbar artery perforator (LAP) flap is another microvascular option for patients who desire autologous breast reconstruction.** **<u>To the Coding Section</u>:** • **<u>CPT Codes Section</u>:** CPT Codes were deleted from this Policy: 19324, and 19366. • **<u>To the HCPCS Code Section</u>:** **<u>The following HCPCS Codes were added to the Policy</u>:** **C1781.** • **<u>To the ICD-10 Codes Section</u>:** **<u>The following ICD-10 Codes were added to the Policy</u>:** **C50.422, N62, and Z48.3.** **<u>To the References Section</u>:** • **<u>The following References were added to the Policy</u>:** #8, 9, 10, 12, 13, 24, 25, 27, and 28.
September 21, 2023	**Review**	**References Updated.** **<u>To the Indications Section</u>:** **Products were added to the Section IV Experimental, Investigational or Unproven:** "DermACELL™" and "FlexHD® Acellular Hydrated Dermis". **<u>To the Coding Section</u>:** • **<u>CPT Codes Section</u>:** **<u>CPT Codes were deleted from this Policy:</u>** 13100, 13101, and +13102 • **<u>New CPT Codes were added to the Policy</u>:** 14000, 14001, 15771, and +15772. • **<u>To the ICD-10 Codes Section</u>:** **<u>The following ICD-10 Codes were added to the Policy</u>:** D48.61, D48.62, N65.0, N65.1, Z15.01, Z90.11, Z90.12, Z90.13, and Z98.82. **<u>To the References Section</u>:** **<u>The following References were added to the Policy</u>:** #14, 18, 26, and 30.
February 26, 2024	**Review**	**<u>To the Coding Section</u>:** • **<u>To the HCPCS Codes Section:</u>** **<u>The following ICD-10 Codes were deleted to the Policy:</u>** C9360. • **<u>To the ICD-10 Codes Section</u>:** **<u>The following ICD-10 Codes were added to the Policy</u>:** N64.81 **<u>The following ICD-10 Codes were deleted from this Policy</u>:** T85.818D, T85.818S, T85.828D, T85.828S, T85.838D, T85.838S, T85.848D, T85.848S, T85.858D, T85.858S, T85.868D, T85.868S, and Z42.8. **<u>To the References Section</u>:**

		The following References were added to the Policy: #1, 5, and 7.
April 09, 2024	**Revised**	New Rationale Section was added to the Policy. 04/09/2024.
August 27, 2024	**Revised**	**References updated.**

[i] **Capsulotomy** is a procedure in which part of the "capsule" of scar tissue surrounding a breast implant is removed or the tissue altered or released in some way.

[ii] **Capsulectomy** is a procedure in which the entire "capsule" of scar tissue surrounding a breast implant is surgically removed.

[iii] **Mastopexy** or breast lift surgery refers to a group of elective surgical operations designed to lift or change the shape of a person's breasts.