

## **Breast Reconstruction Following Mastectomy**

### **MPM 2.11**

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#### **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 women and men 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. As described in this Medical Policy, 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 for mastectomy may be immediate (at the same time as the mastectomy) or delayed. The selection of reconstruction may be based on an assessment of cancer treatment, patient body habitus, smoking history, comorbidities and patient concerns.<sup>1</sup>

This Medical Policy refers to breast reconstruction after mastectomy only.

- See MPM 2.2 for *Breast Implant Removal and/or Replacement and Capsulectomy*.
- See MPM 2.5 for *Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy*.
- See MPM 16.10 for *Prophylactic Mastectomy and Oophorectomy for Prevention of Cancer*.
- See MPM 17.6 for *Restorative/Reconstructive/Cosmetic Treatment and Surgery* for information on chest wall deformity and breast augmentation.

#### **Coverage Determination**

**Benefit Certification is required. Logon to Pres Online to submit a request: <https://ds.phs.org/preslogin/index.jsp>**

Breast reconstruction following a medically necessary mastectomy is mandated coverage by the Women's Health and Cancer Rights Act of 1998. The following is an excerpt from the Act :

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.<sup>2</sup>

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## Breast Reconstruction Following Mastectomy

**Exclusion**                      **Cosmetic surgery performed primarily to improve appearance and self-esteem is not a covered benefit.**

**Coding**                        **The coding listed in this Medical Policy is for reference only. Covered and non-covered codes may be included in this list.**

<b>CPT Codes</b>	<b>Description</b>
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
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
15330	Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children
15331	Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
19316	Mastopexy
19318	Reduction mammoplasty
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
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
19366	Breast reconstruction with other technique
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

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<b>HCPCS® Codes</b>	<b>Description</b>
C1789	Prosthesis, breast (implantable)
J7344	Dermal (substitute) tissue of human origin, with or without other Bioengineered or processed elements, without metabolically active elements, per square centimeter
L8600	Implantable breast prosthesis, silicone or equal
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

<b>ICD-9® Diagnosis Codes</b>	<b>Description</b>
174.0–174.9	Malignant neoplasm of female breast
175.0–175.9	Malignant neoplasm of male breast
198.81	Secondary malignant neoplasm of other specified sites; breast
232.5	Carcinoma in situ of skin of trunk, except scrotum
233.0	Carcinoma in situ of breast
611.83	Capsular contracture of breast implant
612.0	Deformity of reconstructed breast.
612.1	Disproportion of reconstructed breast
996.52	Mechanical complication of other specified prosthetic device, implant, and graft; due to graft of other tissue, not elsewhere classified
996.54	Mechanical complication of other specified prosthetic device, implant, and graft; due to breast prosthesis
996.69	Infection and inflammatory reaction due to internal prosthetic device, implant, and graft; due to other internal prosthetic device, implant, and graft
996.79	Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft; due to other internal prosthetic device, implant, and graft
V10.3	Personal history of malignant neoplasm; breast
V45.71	Acquired absence of breast
V50.41	Prophylactic organ removal: breast
V51.0	Aftercare involving plastic surgery
V52.4	Fitting and adjustment of breast prosthesis and implant

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**Reviewed by:** 1. John Finley, MD, PMG Plastic Surgery, Albuquerque, NM. October 2008.

**References:**

1. National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology™. Breast Cancer. V.1.2010.
2. Centers for Medicare and Medicaid Services. The Women's Health and Cancer Rights Act. Title IX, Sec. 173. Required Coverage for Reconstructive Surgery Following Mastectomy. Accessed 10-20-09:  
[http://www.cms.hhs.gov/HealthInsReformforConsume/Downloads/WHCRA\\_Statute.pdf](http://www.cms.hhs.gov/HealthInsReformforConsume/Downloads/WHCRA_Statute.pdf)

**Approval Signatures:** **Clinical Quality Committee:** Mark Whitaker MD

**Medical Director:** Albert Rizzoli MD

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- 11-19-09: Annual Review and Revision
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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 on the Internet at:  
<http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm>