MEDICAL POLICY

POLICY TITLE	**RECONSTRUCTIVE BREAST SURGERY INCLUDING MANAGEMENT OF BREAST IMPLANTS, EXTERNAL BREAST PROSTHESIS AND POST MASTECTOMY BRAS**
POLICY NUMBER	**MP 1.103**

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**1/1/2025**

I. POLICY

Augmentation mammoplasty may be considered reconstructive and **medically necessary** when there is documented clinical evidence of one of the following:

- Surgery for benign disease when a subcutaneous mastectomy is performed with immediate or delayed prosthesis; **OR**
- Following a previous mastectomy for benign or malignant disease including the unaffected breast to provide symmetry with the breast on which the radical or modified radical mastectomy was performed. (Act 51 of 1997); **OR**
- Unilateral or bilateral breast aplasia; **OR**
- Unilateral breast hypoplasia with significant breast asymmetry when associated with abnormalities of the chest wall. Examples include, but are not limited to, Poland syndrome, Jeune syndrome, pectus excavatum, pectus carinatum, or trauma; **OR**
- Gender affirmation in accord with MP 1.144 Gender Affirming Surgery

Augmentation mammoplasty performed for any other reasons is considered **cosmetic** and is **not medically necessary**.

Reconstruction may be performed by an implant-based approach or through the use of autologous tissue. Explantation and/or capsulotomy of a ***silicone*** gel-filled breast implant may be considered **medically necessary** in all cases for any of the following indications:

- breast implant-associated anaplastic large cell lymphoma (BIA-ALCL);
- documented implant rupture;
- infection;
- extrusion;
- Baker Class IV contracture; or

- Surgical treatment of breast cancer

Explantation &/or capsulotomy of a ***saline***-filled breast implant may be considered **medically necessary** for any of the following indications**:**

- breast implant-associated anaplastic large cell lymphoma (BIA-ALCL);
- infection;
- extrusion;
- Baker Class IV contracture;
- surgical treatment of breast cancer; or
- a ruptured implant if the original breast implantation was for reconstructive purposes;
- a ruptured implant if a recalled textured product

Explantation and/or capsulotomy of a breast implant associated with a Baker Class III contracture may be considered **medically necessary** only in those patients who had originally undergone breast implantation for reconstructive purposes.

Reconstructive breast surgery after explantation of an implant may be considered **medically necessary** only in those patients who had originally undergone breast implantation for reconstructive purposes.

Mastopexy or reduction mammoplasty may be considered **reconstructive and medically necessary** only when performed on the unaffected breast following previous mastectomy when the purpose is to provide symmetry with the breast on which the mastectomy has been performed.

The use of adipose-derived stem cells, alone or in conjunction with autologous fat grafting for reconstructive breast surgery, is considered **investigational** as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Patients who have originally undergone implantation of a cosmetic breast implant are not candidates for additional reconstructive surgery or replacement implantation following surgery.

The following indications for explantation of implants are considered **not medically necessary**:

- Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases;
- Anxiety;
- Baker class III contractures in individuals with implants for cosmetic purposes;
- Rupture of a saline implant in individuals with implants for cosmetic purposes;
- Pain not related to contractures;
- Preventive explantation in asymptomatic individuals to reduce remote risk of anaplastic large cell lymphoma;

- Preventive explantation in asymptomatic individuals to reduce remote risk of B cell lymphoma

Products for Use in Breast Reconstructive Surgery

Use of allogeneic acellular dermal matrix products* (i.e., AlloDerm®, AlloMax™, DermACELL®, DermaMatrix™, FlexHD®, GraftJacket®) may be considered **medically necessary** for use in breast reconstructive surgery.

External Breast Prosthesis/Post Mastectomy Bras

An external breast prosthesis is considered **medically necessary** for a patient who has had a mastectomy.

Only one breast prosthesis per side is considered **medically necessary** for the useful lifetime of the prosthesis. Two prostheses, one per side, are considered **medically necessary** for those persons who have had bilateral mastectomies. More than one external breast prosthesis per side is considered **not medically necessary**.

Two to four post-mastectomy replacement bras are considered **medically necessary** every 12 months.

Two compression lymphedema sleeves ("mastectomy sleeves") may be considered **medically necessary** initially per affected arm, then two replacements, per affected arm, every six months.

Custom fabricated breast prostheses are **medically necessary** following a mastectomy when ordered by the patient's physician.

Policy Guidelines

Application of the above policy regarding explantation of implants requires documentation of the original indication for implantation and the type of implant, either saline- or silicone gel-filled, and the current symptoms, either local or systemic. The following chart should facilitate determination of the medical necessity of explantation. Yes indicates that the explantation would be considered medically necessary, given the symptoms, type of implant, and original indication for implantation.

Indication/Type of Implant

Indication for Explantation	Reconstruction/ Silicone	Reconstruction/ Saline	Cosmetic/ Silicone	Cosmetic/ Saline
Systemic Illness				
Connective tissue disease	no	no	no	no

Autoimmune disease	no	no	no	no
Rheumatic conditions	no	no	no	no
Neurologic symptoms	no	no	no	no
Fibromyalgia	no	no	no	no
Chronic fatigue syndrome	no	no	no	no
Anxiety	no	no	no	no
Absolute Medical Indications				
Rupture*	yes	yes	yes	no
Baker class IV contracture	yes	yes	yes	yes
Recurrent infection	yes	yes	yes	yes
Extruded implant	yes	yes	yes	yes
Surgery for breast cancer	yes	yes	yes	yes
Other Indications				
Baker class III contractures	yes	yes	no	no
Pain**	no	no	no	no
To reduce remote risk of anaplastic large cell lymphoma	no	no	no	no
To reduce remote risk of B cell lymphoma	no	no	no	no
Post-ExplantationProcedures				
reimplantation of implants	yes	yes	no	no
autologous reconstruction	yes	yes	no	no

*Rupture of implants requires documentation with an imaging study, such as mammography, magnetic resonance imaging, or ultrasonography. Lack of imaging confirmation of rupture in association with persistent local symptoms is considered case by case.
** Pain as an isolated symptom is an inadequate indication for explantation. The pain should be related to the Baker classification or a diagnosis of rupture.

Cross-references:

MP 1.004 Cosmetic and Reconstructive Surgery
MP 1.013 Reduction Mammoplasty for Breast-Related Symptoms
MP 1.017 Bio-Engineered Skin and Soft Tissue Substitutes
MP 1.036 Risk Reducing Mastectomy and Bilateral or Salpingo-Oophorectomy
MP 1.144 Gender Affirming Surgery

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II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross please see additional information below, and subject to benefit variations as discussed in Section VI below.
FEP PPO – Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:
https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND TOP

Reconstructive Breast Surgery

Reconstructive breast surgery is defined as a surgical procedure that is designed to restore the normal appearance of the breast after surgery, accidental injury, or trauma. Breast reconstruction is distinguished from purely cosmetic procedures by the presence of a medical condition, e.g., breast cancer or trauma, which leads to the need for breast reconstruction.

The most common indication for reconstructive breast surgery is a prior mastectomy; in fact, benefits for reconstructive breast surgery in these individuals are a mandated benefit in many states. In contrast, cosmetic breast surgery is defined as surgery designed to alter or enhance the appearance of a breast that has not undergone surgery, accidental injury, or trauma. Reduction mammaplasty is a common example of cosmetic breast surgery, but surgery to alter the appearance of a congenital abnormality of the breasts, such as tubular breasts, would also be considered cosmetic in nature.

The following policy describes different types of reconstructive breast surgery and reviews the evidence on efficacy for the different approaches. It also establishes criteria for the explantation of breast implants based on indication, whether the original implant was cosmetic or reconstructive in nature, and whether the implant is silicone gel-filled or saline-filled.

Augmentation mammoplasty is the surgical enlargement of the breast, either to increase breast size or to replace a full or partial breast that has surgically been removed or congentially absent. Surgeries are designed to restore the normal appearance of the breast. The augmentation is done by utilizing autogenous tissue such as a muscle flap graft or by inserting a gel or saline filled prosthesis.

Fat Grafting to the Breast

Following a mastectomy, patients often experience pain and irradiated skin; as an adjunct to reconstructive breast surgery, surgeons will sometimes graft autologous fat to the breast. Adipose-derived stem cells (ADSCs) have been proposed as a supplement to the fat graft in an attempt to improve graft survival; however, whether ADSCs play a role in tumorigenesis is still relatively unknown. Autologous fat grafting is a procedure where the patient's fat cells are

collected from other parts of the body, processed, and then reinserted into the breast area. Autologous fat grafting to the breast has been proposed for indications that include breast augmentation following oncologic surgery. Grafting would be performed as an adjunct to reconstruction after mastectomy or lumpectomy, and it would be of benefit in the following areas: for contouring purposes, improving breast shape and volume; and for alleviating post-mastectomy pain syndrome (neuropathic pain) and irradiated skin (thereby reducing complication and failure rates of implant reconstruction). Variability in long-term results and oncologic concerns have limited application of autologous fat grafting in the breast.

Adipose-Derived Stem Cells

Stem cell biology and the related field of regenerative medicine involve multipotent stem cells that exist within a variety of tissues, including bone marrow and adipose tissue. A single gram of adipose tissue yields approximately 5000 stem cells; this is 100 to 500 times the number of mesenchymal stem cells found in an equivalent amount of bone marrow. Stem cells, because of their pluripotentiality and unlimited capacity for self-renewal, offer promise for tissue engineering and advances in reconstructive procedures. In particular, adipose tissue represents an abundant and easily accessible source of adipose-derived stem cells (ADSCs), which can differentiate along multiple mesodermal lineages. ADSCs may allow for improved graft survival and the generation of new fat tissue after transfer from another site.

The potentially therapeutic properties of ADSC have led to novel techniques of fat grafting in conjunction with ADSC therapy for breast fat grafting. Differentiation of ADSC into adipocytes may provide a reservoir for adipose tissue turnover. Differentiation of ADSC into endothelial cells, with the release of angiogenic growth factors by ADSC, may decrease the rate of graft resorption by increasing blood supply to the grafted fat tissue. Further, ADSC may serve to accelerate wound healing and protect the graft from ischemia reperfusion injury. Current methods for isolating ADSCs can involve various processes, which may include centrifugation and enzymatic techniques that rely on collagenase digestion-which, in turn, is followed by centrifugal separation to isolate the stem cells from primary adipocytes. Isolated ADSCs can be expanded in a monolayer on standard tissue culture plastic surfaces with a basal medium containing 10% fetal bovine serum. Newly developed culture conditions provide an environment in which the study of ADSCs can be done without the interference of animal serum and may also allow rapid expansion of autologous ADSCs in culture for use in human clinical trials. A standard expansion method has not yet been established.

To address the problems of unpredictability and low rates of fat graft survival, Yoshimura et al (2008) developed a technique known as cell-assisted lipotransfer, which produces autogenous fat rich in ADSCs. In cell-assisted lipotransfer, half of the lipoaspirate is centrifuged to obtain a fraction of concentrated ADSCs; meanwhile, the other half is washed, enzymatically digested, filtered, and spun down to an ADSC-rich pellet. The latter is then mixed with the former, converting a relatively ADSC-poor aspirated fat to ADSC-rich fat.

A point-of-care system is available for concentrating ADSC from mature fat. The Celution System is designed to transfer a patient's adipose tissue from one part of the body to another in the same surgical procedure.

In 2011, the American Society for Aesthetic Plastic Surgery and the American Society of Plastic Surgeons released a joint position statement on the use of stem cells in aesthetic surgery. Based on a systematic review of the peer-reviewed literature, the Societies concluded that while there is potential for the future use of stem cells in aesthetic surgical procedures, the scientific evidence and other data are very limited in terms of assessing the safety or efficacy of stem cell therapies in aesthetic medicine.

External Breast Prothesis

External Breast Prothesis is an artificial breast either worn inside a bra or attached directly to the chest wall after breast surgery. Mastectomy bras are designed with a pocket to hold a prosthesis, or the prosthesis is assimilated into the bra itself. Manufacturers make a wide selection of types, shapes, sizes, and colors. They may be made from silicone gel, foam, fiberfill, or other materials that feel similar to natural tissue. They can be asymmetrical (designed only for the left or right side) or symmetrical (designed to be used on either side). A custom fabricated prosthesis is molded specifically to the patient's chest by making an impression of the chest wall. In general, prefabricated prostheses can adequately meet the external prosthetic needs of most patients.

Regulatory Status

In July 2019, Allergan voluntarily recalled Natrelle Biocell textured breast implants and tissue expanders from the market. The recall notice stated, "Allergan is taking this action as a precaution following notification of recently updated global safety information concerning the uncommon incidence of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) provided by the U.S. Food and Drug Administration (FDA). Smooth surfaced implants are not affected by this recall. FDA and other health authorities have not recommended removal or replacement of textured breast implants or tissue expanders in asymptomatic individuals.

In October 2021, FDA issued additional orders restricting the sale and distribution of breast implants. The orders required new labeling including a boxed warning, a patient decision checklist, updated silicone gel-filled breast implant rupture screening recommendations, a device description with a list of specific materials used in the device, and a patient device card. FDA recommended that the boxed warning include the following components:

- Breast implants are not considered lifetime devices;
- The chance of developing complications increases over time;
- Some complications will require more surgery;
- Breast implants have been associated with the development of a cancer of the immune system called BIA-ALCL;

- BIA-ALCL occurs more commonly in patients with textured breast implants than smooth implants, and deaths have occurred from BIA-ALCL; and
- Breast implants have been associated with systemic symptoms.

The orders apply to the following devices:

- IDEAL IMPLANT Structured Saline Breast Implants
- Mentor Saline-Filled and Spectrum Breast Implants
- Inamed (now Allergan) Natrelle Saline Filled Breast Implants
- Inamed (now Allergan) Natrelle Silicone Filled Breast Implants
- Mentor MemoryShape Silicone Gel-Filled Breast Implants
- Mentor MemoryGel Silicone Gel-Filled Breast Implants
- Sientra OPUS Silicone Gel Breast Implants

IV. RATIONALE

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Summary of Evidence

For individuals who have undergone breast surgery or who have experienced injury or trauma to the breast who receive breast reconstruction surgery, the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. The evidence supports the conclusion that breast reconstruction improves psychosocial outcomes, such as anxiety, social functioning, and perception of body image. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants and documented implant rupture, infection, extrusion, Baker contracture, or surgical treatment of breast cancer who receive breast implant explantation the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Local complications of breast implants are common and may require explantation. The medical necessity of implant explantation is dependent on the type of implant, the indication for removal, and the original indication for implantation. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For asymptomatic individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, or surgical treatment of breast cancer who receive preventive breast implant explantation to reduce remote risk of anaplastic large cell lymphoma (ALCL), the evidence includes prospective and retrospective epidemiological cohort studies, case series, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-

related mortality, and treatment-related morbidity. Systematic reviews of epidemiological studies and government regulatory epidemiologic databases have evaluated the risk of breast implant-associated ALCL (BIA-ALCL). Estimates varied widely, with the highest incidence associated with textured implant products that are no longer marketed in the United States. The certainty of the evidence is limited by insufficient follow-up duration to assess risk and lack of standardization of clinical outcome data collection. Additionally, there is no evidence evaluating whether removal of implants reduces ALCL risk, and there are known risks of explantation surgery. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with breast implants without documented implant rupture, infection, extrusion, Baker contracture, or surgical treatment of breast cancer who receive preventive breast implant explantation to reduce remote risk of B cell lymphoma, the evidence includes case reports. Relevant outcomes are overall survival, disease-specific survival, morbid events, functional outcomes, health status measures, quality of life, treatment-related mortality, and treatment-related morbidity. Recent case reports and small case series (N=3 to 8 cases) have described B cell lymphomas occurring in individuals with breast implants. More data are needed to determine if breast implants are associated with an increased risk of B cell lymphoma. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have breast cancer who receive autologous fat grafting to the breast with ADSC enrichment of the graft, the evidence includes small single-arm studies, some of which are prospective. Relevant outcomes are symptoms, morbid events, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. The observational studies were heterogeneous in the patient selection, methods in harvesting stem cells, number of procedures, and outcomes measured. Studies have mainly reported patient and investigator satisfaction and functional and cosmetic results. One small, prospective study found that the use of ADSC enrichment with autologous fat grafting over autologous fat grafting alone improved the retention rate of the fat graft postoperatively at 6 and 12 months. Larger clinical trials are needed to confirm this benefit. Limitations of the data include sample sizes, short-term follow-up, and uncertainty about the possible oncologic influence ADSC may have on the fat grafting procedure. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

V. DEFINITIONS

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ACT 51 OF 1997 –THE MASTECTOMY ACT is a Pennsylvania mandate that prohibits health insurance companies from requiring mastectomies be performed on an outpatient basis. Other requirements include coverage for: One home health visit within 48 hours after discharge when the discharge is within 48 hours of the admission for the mastectomy; Reconstructive surgery, including surgery to re-establish symmetry; and mastectomy–related prosthetic devices.

APLASIA is complete absence of organ or tissue development.

AUTOLOGOUS refers to originating within an individual; i.e., self-donation.

CAPSULOTOMY refers to division of a capsule as around a breast implant; creation of an opening through a capsule; e.g., of a scar that might form around a foreign body.

CONTRACTURE refers to fibrosis of connective tissue in skin, fascia, muscle, or a joint capsule that prevents normal mobility of the related tissue or joint.

COSMETIC SURGERY is an elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function but is considered unpleasant or unsightly.

EXPLANTATION refers to the removal of an implant**.**

HYPOPLASIA is the underdevelopment of a tissue organ or body.

MAMMOPLASTY refers to plastic reconstructive surgery of the breast.

MASTECTOMY per Act 81 is defined as: the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician. (This is NOT restricted to cancer indications.)

MASTOPEXY is the correction of a pendulous breast or surgical fixation and plastic surgery.

PROSTHETIC DEVICES refers to the initial and subsequent artificial devices, including custom artificial devices, to replace the removed breast or portions thereof, ordered by the patient's physician.

RECONSTRUCTIVE SURGERY is a procedure performed to improve or correct a functional impairment, restore a bodily function, or correct a deformity resulting from birth defect or accidental injury. The fact that a member might suffer psychological consequences from a deformity does not, in the absence of bodily functional impairment, qualify surgery as being reconstructive surgery.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are

different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
11920	11921	11922	15771	15772	19316	19318	19325	19328
19330	19340	19342	19350	19355	19357	19361	19364	19367
19368	19369	19370	19371	19380	19396	19499	A4100	C1789
L8000	L8001	L8002	L8010	L8015	L8020	L8030	L8035	L8039
L8600	Q4100	Q4107	Q4116	Q4122	Q4128	S2066	S2067	S2068

ICD-10-CM Diagnosis Codes	Description
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
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

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ICD-10-CM Diagnosis Codes	Description
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
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
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
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
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
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
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
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
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
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
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

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ICD-10-CM Diagnosis Codes	Description
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
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
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
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
C79.81	Secondary malignant neoplasm of breast
D05.00	Lobular carcinoma in situ of unspecified breast
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
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
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
D24.9	Benign neoplasm of unspecified breast
D48.60	Neoplasm of uncertain behavior of unspecified breast
D48.61	Neoplasm of uncertain behavior of right breast

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ICD-10-CM Diagnosis Codes	Description
D48.62	Neoplasm of uncertain behavior of left breast
M95.4	Acquired deformity of chest and rib
N61.1	Abscess of the breast and nipple
N64.82	Hypoplasia of breast
N64.89	Other specified disorders of breast
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
Q79.8	Other congenital malformations of musculoskeletal system
Q83.0	Congenital absence of breast with absent nipple
Q83.8	Other congenital malformations of breast
Q83.9	Congenital malformation of breast, unspecified
T85.41XA	Breakdown (mechanical) of breast prosthesis and implant, initial encounter
T85.41XD	Breakdown (mechanical) of breast prosthesis and implant, subsequent encounter
T85.42XA	Displacement of breast prosthesis and implant, initial encounter
T85.42XD	Displacement of breast prosthesis and implant, subsequent encounter
T85.43XA	Leakage of breast prosthesis and implant, initial encounter
T85.43XD	Leakage of breast prosthesis and implant, subsequent encounter
T85.44XA	Capsular contracture of breast implant, initial encounter
T85.44XD	Capsular contracture of breast implant, subsequent encounter
T85.49XA	Other mechanical complication of breast prosthesis and implant, initial encounter
T85.49XD	Other mechanical complication of breast prosthesis and implant, subsequent encounter
T86.698A	Other mechanical complication of other specified internal prosthetic devices, implants and grafts, initial encounter
T85.698D	Other mechanical complication of other specified internal prosthetic devices, implants and grafts, subsequent encounter
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
T85.828A	Fibrosis due to other internal prosthetic devices, implants and grafts, initial encounter
T85.828D	Fibrosis due to other internal prosthetic devices, implants and grafts, subsequent encounter

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ICD-10-CM Diagnosis Codes	Description
T85.848A	Pain due to other internal prosthetic devices, implants and grafts, initial encounter
T85.848D	Pain due to other internal prosthetic devices, implants and grafts, subsequent encounter
T85.890A	Other specified complication of nervous system prosthetic devices, implants and grafts, initial encounter
T85.890D	Other specified complication of nervous system prosthetic devices, implants and grafts, subsequent encounter
T85.898A	Other specified complication of other internal prosthetic devices, implants and grafts, initial encounter
T85.898D	Other specified complication of other internal prosthetic devices, implants and grafts, subsequent encounter
Z42.1	Encounter for breast reconstruction following mastectomy
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury
Z45.811	Encounter for adjustment or removal of right breast implant
Z45.812	Encounter for adjustment or removal of left breast implant
Z45.819	Encounter for adjustment or removal of unspecified breast implant
Z80.3	Family history of malignant neoplasm of breast
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
Z98.82	Breast implant status

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X. POLICY HISTORY

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MP 1.103	**08/12/2020 Consensus Review.** Policy statement unchanged, references and coding reviewed.
	12/11/2020 Administrative Update. Removed Deleted Codes 19324 & 19366
	08/03/2021 Consensus Review. Policy statement unchanged, references and coding reviewed.
	03/11/2022 Administrative Update. New code A4100 added; effective 4/1/2022
	09/28/2022 Minor Review. Policy title changed to "Reconstructive Breast Surgery/Management of Breast Implants, External Breast Prosthesis and Post Mastectomy Bras" to include External Prosthesis and Post Mastectomy Bras. Added that external breast prosthesis are medically necessary after a mastectomy. Criteria regarding number and lifetime use of external breast prosthesis, post mastectomy replacement bras and lymphedema sleeves added. Included custom fabricated breast prosthesis are medically necessary when ordered by the patient's physician. FEP language revised. Background and References updated. NCCN language added. Added the following codes to the policy: L8000, L8001, L8002, L8010, L8015, L8020, L8030, L8035, L8039, Q4122.
	03/01/2023 Minor Review. Policy title changed from Reconstructive Breast Surgery/Management of Breast Implants, External Breast Prosthesis and Post Mastectomy Bras to Reconstructive Breast Surgery Including Management of Breast Implants, External Breast Prosthesis and Post Mastectomy Bras. Removed first paragraph in policy statement on Reconstructive breast surgery. Added criteria for Augmentation Mammoplasty. Added statement that adipose-derived stem cells are investigational. Added indications when explantation of implants is considered not medically necessary. Background, Rationale, Definitions and References updated. Added codes 15771, 15772, 19325, 19340, 19342, 19350, 19386, C1789, L8600, C50.011, C50.012, C50.019.C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, D24.1, D24.2, D24.9, M95.4, N64.82, N65.0, N65.1, Q79.8, Q83.0, Q83.8.

POLICY TITLE	RECONSTRUCTIVE BREAST SURGERY INCLUDING MANAGEMENT OF BREAST IMPLANTS, EXTERNAL BREAST PROSTHESIS AND POST MASTECTOMY BRAS
POLICY NUMBER	MP 1.103

	02/13/2024 Consensus Review. No change to policy statement. References updated.
	11/19/2024 Administrative Update. NCCN statement removed.

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