Breast surgery

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

Prior authorization is not required for:
- Breast reconstruction following a covered mastectomy or lumpectomy (including surgery for asymmetry)
- Breast reconstruction for Poland syndrome

Prior authorization is required for:
- Augmentation mammoplasty not related to a mastectomy/lumpectomy
- Mastopexy (breast lift) not related to a mastectomy/lumpectomy
- Breast reconstruction to correct a congenital defect other than Poland syndrome
- Breast implant removal and/or replacement

This policy does not address:
- Reduction mammoplasty not related to a mastectomy/lumpectomy
- Surgery for gynecomastia. Please see Related Content at right for links to coverage criteria.

Coverage

Breast surgery is generally covered subject to the indications listed below and per your plan documents.

Indications that are covered

Breast surgery related to mastectomy or lumpectomy
1. Breast reconstruction following a covered mastectomy or lumpectomy is covered. This may include the following procedures:
   A. TRAM flap or similar type of reconstructive breast surgery,
   B. augmentation mammoplasty (including implant placement),
   C. autologous fat injection/transfer
   D. insertion of tissue expanders
   E. use of acellular dermal matrix products; and
   F. nipple and areolar reconstruction, (including tattooing) of the affected breast.
2. Surgery on the contralateral (unaffected) breast is covered following a covered mastectomy or lumpectomy to produce a symmetrical appearance. This may include the following procedures:
   A. augmentation mammoplasty (including implant placement),
   B. mastopexy (breast lift), and/or
   C. reduction mammoplasty (breast reduction).
3. Additional reconstructive breast surgeries related to a covered mastectomy or lumpectomy are only covered when
   A. The initial reconstructive surgery is being done as a staged procedure; or
   B. The initial reconstruction resulted in a medically adverse outcome.

Breast reconstruction to correct a congenital defect
1. Requests for reconstructive breast surgery for congenital syndromes that are directly associated with the absence of breasts (e.g., ectodermal dysplasia), for which member has tried and failed conservative treatment measures (such as appropriate hormone therapies where considered a standard of care), are reviewed on a case by case basis by a medical director.

Implant Removal and/or Replacement:
1. Removal of implants is covered when the original implants were placed for a covered condition.
2. Removal of implants that were placed for a non-covered condition is only covered when painful capsular contracture is present.
3. Removal of silicone implants is covered when there is documented evidence of leaking causing medical complications.
4. Breast implant replacement is covered when the original implants, which were placed for a covered condition (e.g., diagnosis of breast cancer), have been removed.
Indications that are not covered

1. Reconstructive surgery to replace absent breast(s) is covered as described above. However, surgery to change or enhance the appearance of existing breasts is considered cosmetic and not medically necessary. This includes but is not limited to:
   A. Breast reconstruction or augmentation for asymmetrical / hypoplastic / aplastic breasts that do not result from an underlying congenital diagnosis
   B. Removal of breast implants to improve appearance, regardless of why the implants were placed
   C. Mastopexy (breast lift)
   D. Correction of involution (shrinkage) or ptosis (drooping)
   E. Removal of extra axillary breast tissue
   F. Removal of supernumerary (more than two) nipples
   G. Correction of tuberous breast deformity
   H. Correction of inverted nipples

2. Screening using MRI, ultrasound, etc. to determine implant rupture or leaking in asymptomatic individuals is not covered as it is not medically necessary.

Definitions

Acellular dermal matrix (ADM) is used for soft tissue replacement for breast reconstruction after mastectomy. It provides biologic scaffolding that assists in formation of connective tissue as it stabilizes the position of the pectoralis major muscle in order to prevent upward migration of the muscle. Products include AlloDerm, AlloMax, DermACELL, DermaMatrix, FlexHD, Strattice and SeriSurgical Scaffold

Aplasia is a lack of development of an organ or tissue or of the cellular products from an organ or tissue.

Autologous fat transfer (also called autologous fat grafting or fat injection) involves the removal and relocation of the patient’s own body fat (usually from the abdomen, buttocks or thighs). Liposuction is used to remove the fat, which is then processed and injected into the breast.

Breast implant is a bag or pouch filled with a solution and placed under the skin to rebuild the breast after mastectomy or to enhance the size of a breast in cosmetic breast augmentation surgery.

Breast reconstruction is a procedure in which an expander or an implant or tissue from other parts of the body is used to rebuild the breast.

Ectodermal dysplasias are a group of approximately 150 related disorders that result from faulty development of the ectodermal germ cell layer during embryogenesis. Hypohidrotic ectodermal dysplasia is one form of this condition that can result in amastia (absence of the entire breast). This form can also impact the development or function of the hair, nails, sweat glands and teeth.

Hypoplasia is the incomplete development or under development of an organ or tissue.

Mastopexy, also known as a breast lift, is a procedure which raises the breasts by removing excess skin and tightening the surrounding tissue to reshape and support the new breast contour.

Poland syndrome is a rare congenital condition that causes chest wall deformity. People with Poland Syndrome are missing at least part of the muscle from one side of their chest, sometimes missing one or more rib(s), and may have only one fully developed breast/nipple.

Codes

If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>19120</td>
<td>Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions</td>
</tr>
<tr>
<td>19316</td>
<td>Mastopexy</td>
</tr>
<tr>
<td>19318</td>
<td>Reduction mammoplasty</td>
</tr>
<tr>
<td>19324</td>
<td>Mammoplasty, augmentation: without prosthetic implant</td>
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</tbody>
</table>
### 19325
Mammaplasty, 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

### 19355
Correction of inverted nipples

### 19357
Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

### 19361
Breast reconstruction with latissimus dorsi flap, without prosthetic implant

### 19364
Breast reconstruction with free flap

### 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
Incision of capsule surrounding breast with freeing of scar tissue, open procedure

### 19371
Periprosthetic capsulectomy, breast

### 19380
Revision of reconstructed breast

### 19396
Preparation of moulage for custom breast implant

### 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

### ICD-10 Code | Description
---|---
N65.0 | Deformity of reconstructed breast
N65.1 | Disproportion of reconstructed breast
Q79.8 | Poland Syndrome
Q83.3 | Accessory nipple
Q83.8 | Other congenital malformations of breast
T85.41XA-T85.41XS | Breakdown/mechanical of breast prosthesis and implant
T85.42XA-T85.42XS | Displacement of breast prosthesis and implant
T85.43XA-T85.43XS | Leakage of breast prosthesis and implant
T85.44XA-T85.44XS | Capsular contracture of breast implant
T85.49XA-T85.49XS | Other mechanical complication of breast prosthesis and implant
Z42.1 | Encounter for breast reconstruction following mastectomy
Z45.811-Z45.819 | Encounter for adjustment or removal of breast implant

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**Products**

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan...
has limits or will not cover some items. If there is a difference between this general information and your plan
documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to
Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria
or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.

Approved: Medical Director Committee and Benefits Committee; Approved 07/01/95; Revised 4/15/04, 5/4/12,
8/24/2015, 3/21/17, 5/1/18. Annual Review 4/15/04, 6/1/05, 7/1/06, 8/1/07, 7/1/08, 6/1/09, 5/19/10, 2/2011, 2/2012,
2/2013, 2/2014, 1/2015, 8/2015, 2/2016, 2/2017, 2/2018

References
2. Banikarim, C., & De Silva, N. K. Breast disorders in children and adolescents In: UpToDate, Drutz, J. E., Middleman, A. B. (Eds), UpToDate, Waltham, MA. (Accessed on April 25, 2018.)