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 associated with mastectomy or lumpectomy (including surgery for asymmetry)
- Breast reduction

Prior authorization is required for:

- Augmentation mammoplasty (breast augmentation) not related to a mastectomy or lumpectomy
- Mastopexy (breast lift) not related to a mastectomy or lumpectomy
- Breast reconstruction to correct a congenital defect
- Breast implant removal and/or replacement not related to a mastectomy or lumpectomy

This policy does not address surgery for gynecomastia. Please see Related Content at right for link to coverage criteria.

Coverage

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

- Breast reconstruction associated with mastectomy or lumpectomy is considered medically necessary. This may include the following procedures:
  - TRAM flap or similar type of reconstructive breast surgery,
  - augmentation mammoplasty (including implant placement),
  - autologous fat injection/ transfer
  - insertion of tissue expanders
  - use of acellular dermal matrix products; and
  - nipple and areolar reconstruction, including tattooing of the affected breast.
- Surgery on the contralateral (unaffected) breast to produce a symmetrical appearance is considered medically necessary when associated with mastectomy or lumpectomy. This may include the following procedures:
  - augmentation mammoplasty (including implant placement),
  - mastopexy (breast lift), and/or
  - reduction mammoplasty (breast reduction).
- Surgical revision of tissue protruding at the end of a scar (sometimes referred to as a “dog ear” or standing cone) is considered medically necessary when related to breast reconstruction associated with mastectomy or lumpectomy.

Indications that are covered

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, Poland syndrome, Turner syndrome), for which member has tried and failed conservative treatment measures where appropriate (such as hormone therapies when 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 considered medically necessary when the original implants were placed for reconstructive purposes associated with mastectomy or lumpectomy.
2. Removal of implants that were placed for cosmetic purposes is only considered medically necessary when one of the following conditions is present:
   A. Painful capsular contracture; or
   B. Treatment of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) or breast implant-associated squamous cell carcinoma (BIA-SCC) when there is pathologic confirmation of the diagnosis by cytology or biopsy; or

C. Persistent seroma (confirmed on imaging) or discrete breast mass adjacent to the implant; or
D. Rupture of silicone implants documented on medical imaging.

3. Breast implant replacement is considered medically necessary when the original implants, which were placed for reconstructive purposes associated with mastectomy or lumpectomy, have been removed.
4. When medical necessity criteria are met for implant removal unilaterally, removal of the contralateral implant is also considered medically necessary.

Indications that are not covered

1. The following procedures, when not related to mastectomy or lumpectomy, are 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
   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. Prophylactic removal of breast implants is not considered medically necessary in the absence of symptoms, imaging, or pathologic confirmation that would support a diagnosis of BIA-ALCL or BIA-SCC.

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.

Turner syndrome is a chromosomal disorder that affects development. There are various signs and symptoms of Turner syndrome, which can range from mild to severe. Short stature is the most common feature and usually becomes apparent by age five. Most affected females do not produce the necessary sex hormones for puberty, so they do not have a pubertal growth spurt, start their periods or develop breasts without hormone treatment.

HealthPartners

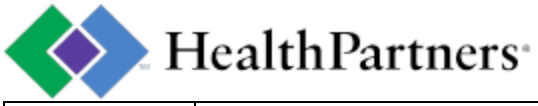
Codes

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.

The services associated with these CPT codes require prior authorization, except when billed with an ICD-10 diagnosis code listed below.

CPT Code	Description
19316	Mastopexy
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (e.g., 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
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 (e.g., 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

ICD-10 Code	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
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
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
N65.0	Deformity of reconstructed breast
N65.1	Disproportion of reconstructed breast
Z15.01	Genetic susceptibility to malignant neoplasm of breast
Z40.01	Encounter for prophylactic removal of breast
Z42.1	Encounter for breast reconstruction following mastectomy
Z85.3	Personal history of malignant neoplasm of breast
Z86.000	Personal history of in-situ 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

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, 4/5/19, 3/31/20, 5/28/2021, 10/19/2022, 01/02/2024. 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, 2/2019, 2/2020, 2/2021, 2/2022, 2/2023, 02/2024

References

1. American Society of Plastic Surgeons (ASPS). (2022). ASPS statement of Breast Implant Associated-Squamous Cell Carcinoma (BIA-SCC). Available from www.plasticsurgery.org.
2. American Society of Plastic Surgeons. (2015). Post-mastectomy fat graft/ fat transfer ASPS guiding principles. Available from www.plasticsurgery.org
3. 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 May 19, 2023.)
4. Clemens, M. W., & Jacobsen, E. Breast implant-associated anaplastic large cell lymphoma. In: UpToDate,Colwell, A. S., & Freedman, A. S. (Eds), UpToDate, Waltham, MA. (Accessed on May 19, 2023.)
5. Clemens, M. W., Jacobsen, E. D., Horwitz, S. M. (2019). 2019 NCCN consensus guidelines on the diagnosis and treatment of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL).*Aesthetic Surgery Journal, 39*(S1), S3-S13. doi: 10.1093/asj/sjy331.
6. ECRI Institute. (2017). *Cosmetic Areola Micropigmentation after Postmastectomy Breast Reconstruction.* Plymouth Meeting, PA: ECRI Institute.
7. Glasberg, S. B., Sommers, C. A., & McClure, G. T. (2023). Breast Implant-associated Squamous Cell Carcinoma: Initial Review and Early Recommendations. *Plastic and reconstructive surgery. Global oper*, *11*(6), e5072.
8. Hayes, Inc. Hayes Health Technology Assessment. *Autologous Fat Grafting for Breast Reconstruction After Breast Cancer Surgery.* Lansdale, PA: Hayes, Inc.; October 2020. Reviewed November 2022.
9. *Hayes, Inc. Hayes Medical Technology Directory Report. Comparative Effectiveness Reviewof Human Acellular Dermal Matrix for Breast Reconstruction. Lansdale, PA: Hayes, Inc.;January 2019. Reviewed February 2022.*
10. Jaffe, E. S., Ashar, B. S., Clemens, M. W., Feldman, A. L., Gaulard, P., Miranda, R. N., … Yoon, S. W. (2020). Best practices guideline for the pathologic diagnosis of breast implant-associated anaplastic large-cell lymphoma. Journal of

Clinical Oncology: Official Journal of the American Society of Clinical Oncology. 2020 Feb 11;:JCO1902778. doi: 10.1200/JCO.19.02778. [Epub ahead of print]
11. Minnesota Statutes, §62A.25 Reconstructive Surgery (2022).
12. Nahabedian, M. Implant-based breast reconstruction and augmentation In: UpToDate, Colwell, A. S., & Chagpar, A. B. (Eds), UpToDate, Waltham, MA. (Accessed on May 19, 2023.)
13. Nahabedian, M. Complications of reconstructive and aesthetic breast surgery. In: UpToDate, Colwell, A. S., & Chagpar, A. B. (Eds), UpToDate, Waltham, MA. (Accessed on May 23, 2023.)
14. Niraula, S., Katel, A., Barua, A., Weiss, A., Strawderman, M. S., Zhang, H., Manrique, O., O'Connell, A., Pandey, S. R., & Dhakal, A. (2023). A Systematic Review of Breast Implant-Associated Squamous Cell Carcinoma *Cancers*, *15*(18), 4516.
15. U.S. Food and Drug Administration, 2023. Update: Reports of Squamous Cell Carcinoma (SCC) in the Capsule Around Breast Implants – FDA Safety Communication. Available on www.fda.gov. Accessed November 24, 2023.
16. Women's Health and Cancer Rights Act of 1998, 9 U.S.C. §§901-903.