

**BREAST RELATED PROCEDURES\***

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*\*This policy includes the following previously separate policies: Breast Implants Explantation, Breast MRI, Breast Reconstruction and Revision Following Surgery for Breast Cancer, Male Gynecomastia, and Mastectomy for Intractable Breast Pain and Reduction Mammoplasty.*

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**II. POLICY/CRITERIA**

**A. Breast Implant Removal**

1. Removal of breast implants that were placed for reconstruction after mastectomy, injury, congenital asymmetry, or augmentation mammoplasty is a covered benefit for the following indications:
  - a. Implants with recurrent infection
  - b. Extruded implants
  - c. Baker Class IV Contracture, associated with severe pain, or
  - d. Breast cancer, new or recurrent (mastectomy and lumpectomy can be done with an implant in place, however, if a breast malignancy is discovered and the surgeon has requested coverage for removal, it is appropriate to provide coverage).
  - e. Implant rupture
2. Replacement/reinsertion of a breast implant is a covered benefit only if the original placement surgery would have been a covered benefit (e.g. if original prosthesis was placed due to cancer surgery, replacement of the prosthesis is a covered benefit; if original surgical indication was cosmetic augmentation, replacement of the prosthesis is not a covered benefit).
3. Removal of breast implants for the following conditions has been determined to not be medically necessary, and therefore, not a covered benefit:
  - a. Breast malposition/asymmetry

- b. Baker Class II or III Contracture\*
- c. Patient anxiety related to the possibility of developing systemic disease, or anxiety related to the influence of breast implants on a current "autoimmune disease". It has not been proven that individuals with breast implants are at an increased risk of developing a systemic disease, or that the implants influence the current status of the systemic disease.
- 4. Pain is frequently cited an indication for removal. The requesting physician should supply clinical information related to the degree of contracture (Baker classification\*), or describe the etiology of the pain.

\* Various systems have been used to classify breast contractures, but the most commonly used is the Baker classification. Four grades are described as follows:

**Grade I** Augmented breast feels soft as a normal breast

**Grade II** Augmented breast is less soft and implant can be palpated, but is not visible

**Grade III** Augmented breast is firm, palpable and the implant (or distortion) is visible

**Grade IV** Augmented breast is hard, painful, cold, tender and distorted

#### **B. Reduction Mammoplasty**

Unilateral and bilateral reduction mammoplasty is a covered benefit according to InterQual criteria.

For augmentation mammoplasty for asymmetry that is not cancer related see C. Breast Reconstruction and Revision below.

Limitations and Exclusions:

- a. Mastopexy procedures (e.g. breast ptosis) are not a covered benefit. These procedures are considered to be cosmetic in nature and not performed to relieve pain due to macromastia.
- b. Reduction mammoplasty for cosmetic purposes (to improve appearance) is not a covered benefit.
- c. Reduction mammoplasty to treat fibrocystic disease of the breasts is not a covered benefit.
- d. Chronic intertrigo, eczema, dermatitis, and/or ulceration in the inframammary fold, in and of itself, are not an indication for coverage.
- e. Coverage is limited to one reduction mammoplasty per member lifetime with Priority Health

#### **C. Breast Reconstruction and Revision**

This section applies to reconstruction and revision for breast cancer. It would also apply to women at high risk of breast cancer who require prophylactic mastectomy.

Initial reconstruction can occur immediately after a mastectomy or be delayed until a patient undergoes radiation or chemotherapy or determines whether she wants breast reconstruction. Some women will opt for immediate breast reconstruction after mastectomy, while some may prefer delayed reconstruction. While some reconstructions can be completed in a single procedure, other techniques may require two or more surgical procedures for completion of the reconstructive process.

Further clarification of coverage for breast reconstruction and revision is outlined below.

1. Coverage for the breast affected by cancer, as well as for the breast(s) removed prophylactically (including bilateral prophylactic mastectomies). The following are covered benefits:
  - a. Treatment for complications of breast reconstruction including cellulitis, other infections, and lymphedema.
  - b. Revisions required by surgical complications including infection, hematoma or seroma, or skin or flap necrosis.
  - c. Capsulotomies/capsulectomies for pain or contractures (see II. A. Breast Implant Removal above) for coverage criteria.
  - d. Prosthesis removal for pain, contractures, rupture, leakage or infection. (See II. A. Breast Implant Removal above) for coverage criteria.
  - e. Scar revisions are only covered if one of the following apply:
    - i. The scar resulted from a serious complication such as infection or wound dehiscence from surgery or post-op period
    - ii. The scar revision is an integral (not incidental) part of another covered procedure
  
2. Additional coverage for the breast(s) removed prophylactically (including bilateral prophylactic mastectomies)\*:
  - a. An initial procedure (reduction, augmentation or mastopexy) on the contralateral breast to produce symmetry between the affected and unaffected breasts.
  - b. A reduction on the unaffected breast is not subject to the 50% copay that applies to reduction mammoplasty unrelated to breast cancer.

\* For specific criteria regarding prophylactic mastectomy for cancer risk reduction see policy # 91508 *Prophylactic Cancer Surgery*

3. Breast reconstruction surgery is also a covered benefit when incidental to disease and/or injury if:

- a. a functional impairment is established and surgery is intended to correct the functional impairment OR
  - b. breast reconstructive surgery is performed to correct asymmetry of a breast when surgery has been performed on the other breast incidental to disease or injury.
4. Coverage is **not** provided for breast reconstruction surgery that is not related to disease or trauma. Excluded conditions include, but are not limited to:
- a. Absence or underdevelopment of chest muscles
  - b. Abnormalities of the chest wall (such as pectus excavatum)
  - c. Congenital underdevelopment or absence of the nipple or breast.

5. **The following are not covered benefits:**

Revisions for aesthetic/cosmetic reasons beyond the original reconstructive surgery unless there were surgical complications such as cellulitis, other infections, lymphedema, hematoma, or significant skin or flap necrosis. Examples of non-covered conditions would include nipple fading, loss of symmetry, for any reason, including tissue atrophy, after initial symmetry is achieved.

*Note:* Treatment or services to prevent chemotherapy-induced hair loss (e.g. cooling therapy or devices during chemotherapy) are considered cosmetic and not covered.

**D. Microsurgical Lymph Node Transplantation for Post mastectomy**

**Lymphedema** is considered experimental and investigational. Review for exceptions may be made in the following circumstances:

1. Chronic recurrent infection, or
2. Clinical functional impairment as defined as a condition which interferes with activities of daily living, and there is reasonable evidence to support that this intervention will correct the condition to which it is being attributed to. Further definition can be located in the Certificate of Coverage.

**E. Male Gynecomastia**

Simple mastectomy or reduction mammoplasty for bilateral male gynecomastia is covered according to InterQual®.

1. Coverage Criteria for Adolescents will follow the requirements below and will require medical review. All of the following must be present:
  - a. Unilateral or bilateral grade III or grade IV symptomatic gynecomastia
  - b. glandular tissue >4 cm in diameter
  - c. persists after 12 months of unsuccessful medical treatment

- d. patient has pain unresponsive to OTC medications and activities of daily living are significantly compromised
2. Coverage for Unilateral Gynecomastia in Adults - Priority Health will cover excisional biopsies for adult males with unilateral gynecomastia when malignancy is suspected.
3. Prior Authorization Requirements for Medicaid members (all of the following are required). The following documentation should be provided by the requesting physician:
  - a. Patient's age
  - b. Physical description of the enlarged breast including symmetry, mass, induration and size
  - c. Medical history assessing the differential diagnosis including chronic diseases and medications
  - d. Previous work-up including mammogram and fine needle aspirate, where appropriate for evaluation of unilateral gynecomastia or masses.
  - e. High-quality original photographs for evaluation of the gynecomastia grade.

**F. Mastectomy for Intractable Breast Pain**

The efficacy and clinical application of mastectomy (simple or total) for intractable breast pain has not been proven to be a medically appropriate treatment and is not a covered benefit.

**G. Screening Mammography, Digital Breast Tomosynthesis and Breast MRI**

1. Screening Mammography  
Screening mammograms, conventional or digital, are a covered benefit. Coverage for screening mammography for an average risk woman is provided according to Michigan law. The State of Michigan requires coverage for one mammogram in a five-year period for women at least 35 years of age and less than 40 years of age. For women 40 years of age and older the State requires coverage for one mammogram per year.

Ultrasound and electrical impedance scans are not a covered benefit as screening tests for breast cancer. Conventional or digital mammography is considered to be the standard diagnostic method for breast cancer screening. MRI for breast cancer screening is only covered as specified below.

2. Digital Breast Tomosynthesis (DBT)
  - a. A screening DBT is considered medically necessary for individuals that have dense breasts.

- b. A diagnostic DBT is considered medically necessary for individuals that have abnormal mammogram findings that require further imaging.
3. Breast MRI  
*eviCore provides prior authorization medical necessity review services on behalf of Priority Health for participating providers. Prior authorization for out-of-network providers must be requested through Priority Health. Breast related procedures may be covered when eviCore criteria are met.*

**III. MEDICAL NECESSITY REVIEW**

**A. Breast Implant Removal**

Required  Not Required  Not Applicable

**B. Reduction Mammoplasty**

Required for all products except HMO, FF POS and Medicare

**C. Breast Reconstruction and Revision**

Required  Not Required  Not Applicable

**D. Microsurgical Lymph Node Transplantation for Post mastectomy Lymphedema**

Required  Not Required  Not Applicable

**E. Male Gynecomastia**

Required for all products except HMO, FF POS and Medicare

**F. Mastectomy for Intractable Breast Pain**

Required  Not Required  Not Applicable

**G. Screening Mammography, Digital Breast Tomosynthesis and Breast MRI**

Required for Breast MRI only  Not Required  Not Applicable

**IV. APPLICATION TO PRODUCTS**

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*

- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-159815--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html). If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_5100-87572--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

## V. DESCRIPTION/BACKGROUND

This policy addresses breast surgery, including reconstruction and revision following breast cancer, gynecomastia and imaging. Policy 91478 Breast Ductal Lavage has been retired. For prophylactic mastectomy, please see medical policy Prophylactic Cancer Risk Reduction Surgery 91508.

### A. Breast Implant Removal

In the US, an estimated 1-2 million patients, or approximately 1% of the adult female population, have breast implants. The incidence of implant rupture increases over time. One study revealed that the median lifespan of a silicone gel breast implant is 16.4 years. In that study, 79.1% of implants were intact at 10 years; the percentage decreased to 48.7% at 15 years.

According to the American Society of Plastic Surgeons, breast augmentation is the third most commonly performed cosmetic procedure in the United States. In 2005, 291,000 breast augmentation procedures were performed. More than 50,000 implant removal procedures were also reported in 2004.

A breast implant is a silicone shell filled with either silicone gel or saline. Some silicone gel may diffuse or “bleed” through the shell of an intact implant into the scar tissue or capsule that surrounds the implant. Rupture of an implant may be related to the length of time it has been in the body. All breast implants, like other medical devices, fail over time and need to be removed or replaced. Rupture may also be related to force or trauma.

Significant local complications of breast implants may require removal of the implant. Contracture is the most common local complication of breast implants.

Capsules of tightly-woven collagen fibers form as an immune response around a foreign body (e.g. breast implants, pacemakers, orthopedic joint prosthetics), tending to wall it off. Capsular contracture occurs when the capsule tightens and squeezes the

implant. This contracture is a complication that can be very painful and distort the appearance of the implanted breast. The exact cause of contracture is not known. However, some factors include bacterial contamination, silicone rupture or leakage, and hematoma.

When saline breast implants break, they often deflate quickly and can be easily removed. Prospective studies of saline-filled breast implants approved by FDA in May 2000 showed rupture/deflation rates of 3-5% at 3 years and 7-10% at 5 years for augmentation patients.

When silicone implants break they rarely deflate, and the silicone from the implant can leak. The differential diagnosis of silicone breast implant rupture includes intracapsular and extracapsular ruptures. If the extruded silicone is contained by this fibrous capsule the rupture is termed intracapsular. If the silicone gel is extruded beyond the capsule, the rupture is termed extracapsular. If intracapsular ruptures are early or focal, extensive gel bleeding has an appearance similar to that of extracapsular rupture by MRI. Extracapsular rupture involves free silicone in the breast parenchyma, which can simulate other breast masses, including breast cancer, at mammography and sonography. An intracapsular rupture can progress to outside of the capsule (extracapsular rupture), and when recognized, both conditions are generally agreed to indicate the need for removal of the implant. Clinically, extracapsular ruptures are often associated with a change in size and consistency of the breast. Extracapsular silicone has the potential to migrate, but most clinical complications have appeared to be limited to the breast and axillae in the form of granulomas (inflammatory nodules) and axillary lymphadenopathy.

### **B. Reduction Mammoplasty**

Macromastia is the development of abnormally large breasts. Macromastia that may require treatment is distinguished from large, normal breasts by the presence of persistent, painful symptoms and physical signs. These commonly include chronic mechanical upper back and/or neck and/or shoulder pain as the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk.

Excessive breast weight may be reduced through a weight reduction management program or through surgical means. Reduction mammoplasty is the surgical excision of a substantial portion of the breast including the skin and the underlying glandular tissue, until a clinically normal size is obtained.

Surgery solely performed to reshape the breasts, in order to improve appearance and self-esteem, is considered to be cosmetic surgery. Reconstructive breast surgery post-mastectomy for breast cancer is a covered benefit and addressed in II. C. above. Treatment for gynecomastia, the excessive growth of the male mammary glands, is addressed in II. E. above.

### **C. Breast Reconstruction and Revision**

Breast reconstruction surgery includes those surgical procedures which are intended to restore the normal appearance of the breast. This restoration occurs after surgery, accidental injury, or trauma.

Mastectomy for cancer is the most common reason women seek breast reconstruction, but other conditions such as severe post radiation changes or congenital deformities are other reasons that a woman may seek breast reconstruction.

Techniques of reconstruction include: tissue expansion, flap reconstruction, nipple areola reconstruction with subsequent implantation of a breast prosthesis. The tissue expander is a balloon-like device which is surgically placed under the chest tissue to create a breast-shaped space for the breast implant. Flap reconstruction allows for reconstruction using the patient's own tissues. Donor flap sites include the back, lower abdomen, buttocks, or lateral hip region. For a latissimus flap the latissimus dorsi muscle is used. This muscle is frequently used for reconstruction surgery due to its large size and versatility. For a TRAM flap (transverse rectus abdominus musculocutaneous flap) excess abdominal tissue is tunneled under the skin from the lower abdomen to the chest and used to replace the breast tissue. For a free flap, tissue from other body sites (such as buttock or lateral thigh region) is transferred to the chest.

Although breast reconstruction is a cosmetic procedure, there are both Federal and Michigan state laws requiring health plans to cover breast reconstruction in certain defined circumstances. The federal and state requirements differ.

#### **D. Male Gynecomastia**

Gynecomastia is defined as the presence of an abnormal proliferation of breast tissue in males. It is a common breast lesion accounting for more than 65 percent of male breast disorders. Gynecomastia has a broad range of causes that are classified as either physiological or pathological, although in many cases no specific cause can be found (idiopathic). In true gynecomastia, the breast enlargement is due to glandular breast tissue; in pseudogynecomastia, the breast enlargement is secondary to fat accumulation; and both glandular and fat tissue are present in mixed gynecomastia.

*Physiologic gynecomastia* occurs most frequently during times of male hormonal changes, resulting from the effect of an altered estrogen/androgen balance on breast tissue or from the increased sensitivity of breast tissue to a normal estrogen level.

*Pubertal gynecomastia* is a common condition with an overall incidence of 38 percent in males 10 to 16 years of age, increasing to 65 percent at age 14, and dropping to 14 percent in 16-year-old boys. During adolescence, 75 percent of the gynecomastia cases are bilateral but the breasts are often affected to different degrees. Pubertal gynecomastia often regresses spontaneously in six months, 75 percent within two years of onset, and 90 percent resolve within three years of onset.

In adults, gynecomastia is associated with increasing age due to progressive testicular hypofunction, an increase in body fat, and an increase in the estrogen/androgen ratio.

**Pathological gynecomastia** is associated with both androgen deficiency and estrogen excess. Both causes may be due to medications, diseases related to endocrinologic abnormalities, tumors, chronic disease, chromosomal abnormalities, familial disorders, and other miscellaneous conditions. While there is always a concern when a mass is present, breast cancer accounts for only 0.2 percent of all malignancies in male patients. A suspicious mass or lesion requires biopsy.

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales:

- Grade I** Small breast enlargement with localized button of tissue that is concentrated around the areola.
- Grade II** Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
- Grade III** Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present.
- Grade IV** Marked breast enlargement with skin redundancy and feminization of the breast.

| <i>Causes of Gynecomastia</i> |                          |
|-------------------------------|--------------------------|
| Physiologic                   | Tumor                    |
| Neonatal                      | Pituitary                |
| Pubertal                      | Adrenal                  |
| Age                           | Testicular               |
| Pathologic                    | Breast                   |
| Drugs, including marijuana    | Chronic Disease          |
| Endocrinopathy                | Liver disease, cirrhosis |
| Primary hypogonadism          | Renal failure            |
| Secondary hypogonadism        | Malnutrition             |
| Hyperthyroidism               | Pulmonary                |
| Adrenal disorders             | Nervous system damage    |
| Familial                      |                          |
| Idiopathic                    |                          |

**E. Screening Mammography and Breast MRI**

*Screening Mammography*

Screening mammography involves radiographic (X-ray) examination of the breast performed at regular intervals, usually every 1 to 2 years, to detect breast cancer before it displays signs or symptoms. The goals of screening mammography for average risk women without any symptoms are to reduce breast cancer morbidity and mortality (illness and death). This can be accomplished by the accurate detection of the disease

before it has metastasized (spread from the breast to another part of the body), when treatment can be less aggressive, and when the likelihood of long-term remission (decrease in symptoms) or cure is the highest.

According to the State of Michigan Insurance Code, breast cancer screening is defined as mammography using a standard 2-view per breast, low-dose radiographic examination of the breasts, and using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

The Insurance Code goes on to define breast cancer diagnostic services as procedures intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammogram, mammography, surgical breast biopsy, and pathologic examination and interpretation.

#### *Breast MRI*

Women with inherited mutations of the *BRCA1* or *BRCA2* gene have the highest risk of breast cancer. They make up 5 to 10 percent of women with breast cancer and are also at increased risk for ovarian cancer. The cumulative risk of breast cancer in women with *BRCA1* mutations is 3.2 percent by the age of 30 years, 19.1 percent by the age of 40, 50.8 percent by the age of 50, 54.2 percent by the age of 60, and 85.0 percent by the age of 70; the cumulative lifetime risk for carriers of *BRCA1* or *BRCA2* mutations is 50 to 85 percent.

Screening mammography detects less than half of the breast cancers in mutation carriers, perhaps owing to young age, dense breasts, or pathological features of the tumor. Cancers in mutation carriers grow rapidly; half of them appear in the interval between annual mammograms. The median size of such "interval cancers" is 1.7 cm, and half have spread to axillary lymph nodes by the time they are detected. It has been suggested that supplementing mammography with other imaging techniques, shorter screening intervals, or both may be valuable in mutation carriers. Liberman, L. "Breast Cancer Screening with MRI—What are the Data for Patients at High Risk?" *New England Journal of Medicine*, 351; 5, July 29, 2004, pp. 497-500.

A recent study suggests that MRI may be a viable option for breast cancer screening among carefully selected women at high risk for the disease due to familial or genetic predisposition. Although concerns regarding an increase in invasive follow-up procedures due to the reduced specificity of MRI screening may be warranted, the anxiety level regarding breast cancer among women with familial or genetic predisposition for the disease is already heightened; therefore, it is difficult to determine the clinical implication of additional follow-up procedures. Furthermore, women in this high-risk category are at greater risk for aggressive forms of the disease at an earlier age; consequently, mammograms are often indicated at a young age when they are less effective due to the dense breast tissue of younger women. MRI may be of value for this patient population; however, further studies are necessary to better define the appropriate patient population, as well as to determine if clinical and survival benefits outweigh the high cost of the procedure. *Kriege M, Brekelmans CT,*

*Boetes C, et al. Efficacy of MRI and mammography for breast-cancer screening in women with a familial or genetic predisposition. N Engl J Med. 2004;351(5):427-437.*

**VI. CODING INFORMATION**

**A. Breast Implant Removal**

**ICD-10 Codes** that may apply:

|                     |  |
|---------------------|--|
| N64.9               | Disorder of breast, unspecified  |
| T85.44xA - T85.44xS | Capsular contracture of breast implant   |
| T85.828A - T85.828S | Fibrosis due to internal prosthetic devices, implants and grafts                 |
| T85.848A - T85.848S | Pain due to internal prosthetic devices, implants and grafts                     |
| T85.898A - T85.89S  | Other specified complication of internal prosthetic devices, implants and grafts |

**CPT/HCPCS Codes**

|       |                                     |
|-------|-------------------------------------|
| 19328 | Removal of intact mammary implant   |
| 19330 | Removal of mammary implant material |

**B. Reduction Mammoplasty**

**ICD-10 Codes** that may apply:

|     |                       |
|-----|-----------------------|
| N62 | Hypertrophy of breast |
|-----|-----------------------|

**CPT/HCPCS Code**

|       |                       |
|-------|-----------------------|
| 19318 | Reduction Mammoplasty |
|-------|-----------------------|

**C. Breast Reconstruction and Revision**

**ICD-10 Codes** that support medical necessity:

|                     |  |
|---------------------|--|
| C50.011 - C50.929   | Malignant neoplasm of breast   |
| C79.81              | Secondary malignant neoplasm of breast   |
| D05.00 - D05.92     | Carcinoma in situ of breast  |
| D07.30              | Carcinoma in situ of unspecified female genital organs   |
| Z40.01              | Encounter for prophylactic removal of breast   |
| Z42.1               | Encounter for breast reconstruction following mastectomy   |
| Z42.8               | Encounter for other plastic and reconstructive surgery following medical procedure or healed injury\ |
| Z85.3               | Personal history of malignant neoplasm of breast   |
| Z90.10 – Z90.13     | Acquired absence of breast and nipples   |
| Z98.82              | Breast implant status  |
| N64.89              | Other specified disorders of breast  |
| T85.44xA - T85.44xS | Capsular contracture of breast implant,  |
| N65.0               | Deformity of reconstructed breast  |
| N65.1               | Disproportion of reconstructed breast  |
| T85.41xA - T84.49xS | Mechanical complication of breast prosthesis and implant   |
| T85.79xA - T85.79xS | Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts    |

|                   |  |
|-------------------|--|
| T85.828A-T85.828S | Fibrosis due to other internal prosthetic devices, implants and grafts                 |
| T85.848A-T85.848S | Pain due to other internal prosthetic devices, implants and grafts                     |
| T85.898A-T85.898S | Other specified complication of other internal prosthetic devices, implants and grafts |

**CPT/HCPCS Codes**

*The above diagnoses support medical necessity for the following procedures. All other indications must be prior authorized.*

|       |  |
|-------|--|
| 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 (List separately in addition to code for primary procedure) |
| 11970 | Replacement of tissue expander with permanent prosthesis   |
| 11971 | Removal of tissue expander(s) without insertion of prosthesis  |
| 19316 | Mastopexy  |
| 19318 | Reduction Mammoplasty ( <i>see Section B for other indications</i> )   |
| 19324 | Mammoplasty, augmentation; without prosthetic implant  |
| 19325 | Mammoplasty, augmentation; with prosthetic implant   |
| 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, with or 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   |
| 19396 | Preparation of moulage for custom breast implant ( <i>not covered for Priority Health Medicaid</i> )   |
| C1789 | Prosthesis, breast (implantable)<br>Bill with Revenue Code 0272 Sterile supply<br>( <i>not separately payable for Priority Health Medicaid</i> )   |

- L8039 Breast prosthesis, not otherwise specified  
Billed with Revenue Code 0274 Prosthetic/orthotic devices  
*(not separately payable for Priority Health Medicaid)*
- L8600 Implantable breast prosthesis, silicone or equal  
Billed with Revenue Code 0278 Other implants  
*(Not separately payable for Priority Health Medicaid)*
- 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 *(S Code is not covered for Priority Health Medicaid and Priority Health Medicare)*
- 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 *(S Code is not covered for Priority Health Medicaid and Priority Health Medicare)*
- 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 *(S Code is not covered for Priority Health Medicaid and Priority Health Medicare)*

**D. Microsurgical Lymph Node Transplantation for Post mastectomy Lymphedema**

**ICD-10 Codes** that may apply:

I97.2 Post mastectomy lymphedema syndrome

**CPT/HCPCS Codes:**

38999 Unlisted procedure, hemic or lymphatic system (Explanatory notes must accompany claim)

**E. Male Gynecomastia**

**ICD-10 Codes** that support medical necessity:

N62 Hypertrophy of breast

**CPT/HCPCS Codes**

15877 Suction assisted lipectomy, trunk *(Not covered for Medicaid)*  
19300 Mastectomy for gynecomastia  
19303 Mastectomy, simple, complete  
19304 Mastectomy, subcutaneous  
19318 Reduction Mammoplasty

**Special Note:** Most benefit plans have a 50% co-pay on professional fees effective 1/1/2003. A rider allowing coverage at a higher level is available to employers.

**F. Mastectomy for Intractable Breast Pain (Not covered)**

**ICD-10 Codes** that apply:

N64.4 Mastodynia

**CPT/HCPCS Codes**

- 19301 Mastectomy, partial; (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
- 19302 Mastectomy, partial; with axillary lymphadenectomy (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
- 19303 Mastectomy, simple, complete
- 19304 Mastectomy, subcutaneous
- 19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes
- 19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
- 19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

**G. Mammography, Digital Breast Tomosynthesis (DBT) and Breast MRI**

Diagnostic Procedures:

- 76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
- 76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
- 77046 Magnetic resonance imaging, breast, without contrast material; unilateral
- 77047 Magnetic resonance imaging, breast, without contrast material; bilateral
- 77048 Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
- 77049 Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed, bilateral
- ~~77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral (prior authorization required)~~
- ~~77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral (prior authorization required)~~
- ~~0159T Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure) (Not covered for Priority Health Medicaid)~~
- 77065 Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
- 77066 Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
- 77061 Digital breast tomosynthesis; unilateral
- 77062 Digital breast tomosynthesis; bilateral
- G0279 *Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77067)*

Screening Procedures:

- 77067 Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
- 77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

**ICD-10 Codes** that support preventive benefit for the following diagnostic procedures if performed for screening indication and converted to diagnostic

- Z12.31 Encounter for screening mammogram for malignant neoplasm of breast
- Z12.39 Encounter for other screening for malignant neoplasm of breast
- Z80.3 Family history of malignant neoplasm of breast
- Z85.3 Personal history of malignant neoplasm of breast

**CPT/HCPCS Codes**

- 77065 Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
- 77066 Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral

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