Breast Surgery
Corporate Medical Policy

File name: Breast Surgery
File code: UM.SURG.17
Origination: 2016
Last Review: 11/2018 (PA List Review)
Next Review: 11/2019
Effective Date: 04/01/2019

Description/Summary

This policy focuses on breast-related procedures that include mastectomy for cancer, prophylactic mastectomy, reconstruction, the management of breast implants, breast reductions, corrections for certain asymmetries. BCBVT covers medically necessary procedures related to physiological dysfunction, such as breast cancer, congenital and developmental disorders, infection, trauma, surgical complications and macromastia causing physiological dysfunction in men and women. BCBSVT considers procedures that are only performed to reshape normal structures of the body in order to improve one’s appearance or self-esteem only, to be cosmetic and therefore non-covered as benefit exclusions.

Policy

Coding Information
Click the links below for attachments, coding tables & instructions.
Attachment I - CPT®/HCPCS Coding Table

Requests for breast surgery should be accompanied by the following documentation:
- The name and date of the proposed surgery.
- Date of accident or injury, if applicable
- History of present illness and/or conditions including diagnoses
- Documentation of diagnosis, functional impairment, pain or significant anatomic variance
- How the treatment can be reasonably expected to improve the functional impairment
- If applicable, the description of and CPT® coding for planned staged procedure following acute repair, within two years of previous stage or initial primary repair
- Any additional information listed for a specific procedure as indicated for the specific procedures listed below.

BCBSVT will review procedures intended to correct complications from a cosmetic procedure, whether the original procedure was medically necessary or a non-covered service. In order
for these corrections to be considered medically necessary the subsequent surgery needs to be reconstructive in nature (i.e. procedures performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate normal appearance).

The procedures in this medical policy are considered **medically necessary** in accordance with the Women’s Health and Cancer Rights Act of 1998, when performed as a breast reconstruction procedure following or in connection with mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast, in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, to prevent development of breast cancer in high risk patients, reconstruction following breast tissue destruction due to accidental injury, trauma, infection or disease (including other cancers).

If the intended service relates to gender reassignment services, please refer to the BCBSVT “Transgender Services” medical policy.

**Policy and Guidelines**


- We consider the procedure **medically necessary** for the following indications:
  - A diagnosis of breast cancer or a history of breast cancer
  - Following a mastectomy for cancer
  - Following a prophylactic mastectomy
  - For absence of the breast due to trauma, disease or infection
  - A diagnosis of Poland’s syndrome
- We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** when:
  - None of the above indications are met.
  - Obtained only to improve appearance or to improve one’s self-esteem.

*When billed with a diagnosis of breast cancer prior approval is not required.*

**Mastectomy for Gynecomastia (CPT® code 19300)** - surgery due to development of abnormally large mammary gland in biologically male individuals.

- We consider the procedure **medical necessary** for the following:
  - With a diagnosis of breast cancer; OR
  - If the criteria for a Prophylactic Mastectomy are met.
  - When all of the following are met:
    - Documented symptoms, including pain or tenderness directly related to the breast tissue, and which has a clinically significant impact upon normal activities of daily living despite non-narcotic analgesics and anti-inflammatory agents; **AND**
    - Appropriate diagnostic evaluation has been done for possible underlying etiology; **AND**
    - The tissue removed must be glandular breast tissue; and
- The extra tissue must not be the result of obesity, adolescence, or reversible effects of drug treatment that can be discontinued. (This includes drug-induced Gynecomastia remaining unresolved six months after cessation of the causative drug therapy;
- Additionally, for those under 18 years of age, one of the following must be submitted as evidence of puberty completion.*

*Evidence of puberty completion:
  - Documented tanner stage IV or V for members aged 15-18, AND
  - Stable height measurements for 6 months, OR
  - Puberty completion as shown on wrist radiograph.

- We consider the procedure not medically necessary when any of the following is present:
  - Conservative attempts to control the pain or tenderness, such as non- narcotic analgesics and anti-inflammatory agents, have not been attempted.
  - Use of a medication known to cause gynecomastia has not been discontinued.
  - The appropriate diagnostic evaluation for etiology has not been completed.

- We consider the procedure cosmetic and therefore not covered as a benefit exclusion for the following circumstances (not an all-inclusive list):
  - The tissue being removed is not glandular in nature; OR
  - The medically necessary criteria above is not met and the procedure is intended only to improve appearance or to improve one’s emotional well-being.

Prophylactic Mastectomy (CPT® codes 19303*, 19304*) - Surgical removal of breasts due to a high cancer risk. It is strongly recommended that all candidates for prophylactic mastectomy undergo counseling regarding cancer risks from a health professional skilled in assessing cancer risk other than the operating surgeon and discussion of the various treatment options, including increased surveillance or chemoprevention with the appropriate medication e.g. tamoxifen or raloxifene.

Patients with a high risk of breast cancer may be defined as one or more of the following:
- a known BRCA1 or BRCA2 mutation or
- at high risk of BRCA1 or BRCA2 mutation due to a known presence of the mutation in relatives or
- another gene mutation associated with increased risk (eg, PTEN, TP53, CDH1, and STK11) or
- Li-Fraumeni syndrome or Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes or
- high risk (lifetime risk about 20% to 25% or greater) of developing breast cancer as identified by models that are largely defined by family history or
- received radiotherapy to the chest between 10 and 30 years of age
- We consider the procedure medically necessary for any of the following:
  - In patients at high risk of breast cancer as defined above.
  - In patients with inflammatory breast cancer.
  - In patients with lobular carcinoma in situ.
- In patients with such extensive mammographic abnormalities (i.e. calcifications) that adequate biopsy or excision is impossible.
- We consider the procedure investigational for all other indications, including, but not limited to contralateral prophylactic mastectomy in women with breast cancer who do not meet the high risk criteria as defined above.

**Breast Reconstruction (CPT® codes 15777, 19340*, 19342*, 19350*, 19357*, 19361*, 19364*, 19366*, 19367*, 19368*, 19369*, 19380*).** Utilization of natural or artificial tissue to reconstruct breasts following mastectomy, breast conservation therapy, burns, trauma and diagnostic deformity

- We consider reconstruction medically necessary for any of the following:
  - For the affected breast
    - When breast tissue is affected by disease, trauma, burns or infection
    - When performed in connection with cancer, the evaluation of cancer, the evaluation of suspected cancer (i.e. following biopsy or lumpectomy), or the prevention of breast cancer development in high risk patients; OR
    - For prostheses and physical complications* of all stages of mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity (i.e. following biopsy or lumpectomy) including lymphedema treatment.

*Physical complications of a staged mastectomy may include, but is not limited to, abdominal scar revision/release related to prior tissue needed for breast reconstruction.
- Following the removal of a ruptured silicone gel-filled implant
- For the unaffected breast
  - in order to create a symmetrical appearance

*When billed with a diagnosis of breast cancer, following an approved mastectomy, prior approval is not required.

- We consider the following cosmetic and therefore not covered as a benefit exclusion:
- Breast reconstruction following mastectomy for gynecomastia.

**Notes:**
- Breast reconstruction utilizing autologous fat grafting to the breast with adipose-derived stem cells is considered investigational. CPT® code 20926 should represent autologous fat grafting from direct harvest and is appropriate.
- Allograft material for use in breast reconstructive therapy (HCPCS Q4100, Q4107, Q4116, Q4122, & Q4128)
  - Implant repositioning
  - Inverted nipple correction- (CPT® 19355)
  - Mastopexy (CPT® 19316*)
- If the preceding criteria for Breast Reconstruction are not met, the following procedures are considered cosmetic and therefore not covered as a benefit exclusion:
  - Mastopexy (CPT® 19316)
  - Inverted nipple correction (CPT® 19355)
• Implant repositioning
• Tattooing of the nipple and/or areola (CPT® Codes 11920, 11921, 11922)

Reduction Mammaplasty (CPT® code 19318) - Surgical reduction of breasts in women due to size and persistent symptoms.

• We consider the procedure medically necessary for the treatment of macromastia for the following:
  – Breast size is stable for six to twelve months prior to surgery. AND
  – A minimum of 6-weeks of two persistent well-documented symptoms which impair function such as shoulder, neck, or back pain or pain interfering with sleep related to macromastia that is not responsive to conservative therapy, such as an appropriate support bra, exercises, heat/cold treatment, and appropriate nonsteroidal anti-inflammatory agents/muscle relaxants OR
  – One of the above symptoms AND recurrent or chronic intertrigo between the pendulous breast and the chest wall that is resistant to topical treatment.
  – Additionally, for those under 18 years of age, one of the following must be submitted as evidence of puberty completion.*

* Evidence of puberty completion:
  • Documented Tanner stage IV or V for members aged 15-18, AND
  • Stable height measurements for 6 months, OR
  • Puberty completion as shown on wrist radiograph.
  • Breast Reduction (Reduction Mammaplasty CPT® 19318) is considered medically necessary when in connection with breast reconstruction following a mastectomy.

• We consider reduction mammoplasty cosmetic and therefore not covered as a benefit exclusion for any of the following:
  o Performed in order to improve athletic performance OR
  o Obtained only to improve appearance or to improve one’s self-esteem

• We consider the procedure investigational for all other indications not outlined above.

• Removal of implant(s) (CPT® codes 19328, 19330); insertion of implant(s) (CPT® codes 19340*, 19342*, C1789*); Periprosthetic capsulotomy or capsulectomy (CPT® codes 19370, 19371): the removal and replacement of breast implants originally placed following mastectomy.

  – Additional Documentation Required:
    o Date of implantation and type of implant
    o Objective evidence of leakage
    o Baker Contracture Class*

• We consider the procedure medically necessary for the any of the following:
  o Explantation (removal of implant) of a silicone gel-filled or saline filled
implant with a documented implant rupture, extrusion, Baker Class IV* contracture, or surgical treatment of cancer or other disease, infection, trauma or burn.

- We consider the procedures **not medically necessary** for the any of the following:
  - Explantation of a when the original reconstruction was for cosmetic reasons and the medically necessary criteria above is not met.
  - Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases, etc.;
  - Baker class III contractures in patients with implants for cosmetic purposes;
  - Rupture of a saline implant in patients with implants for cosmetic purposes;
  - Pain not related to contractures or rupture.

- We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for the following:
  - Obtained only to improve appearance or to improve one’s self-esteem.

| *Baker Classification of breast contractures:*
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Grade I:</td>
<td>Augmented breast feels as soft as a normal breast</td>
</tr>
<tr>
<td>Grade II:</td>
<td>Breast is less soft and the implant can be palpated but is not visible.</td>
</tr>
<tr>
<td>Grade III:</td>
<td>Breast is firm, palpable and the implant (or its distortion) is visible</td>
</tr>
<tr>
<td>Grade IV:</td>
<td>Breast is hard, painful, cold, tender and distorted</td>
</tr>
</tbody>
</table>

- **Unilateral Breast Surgery for Asymmetry - reduction mammoplasty (CPT® code 19318) and/or augmentation mammoplasty (CPT® codes 19324 & 19325)** - surgical reconstruction in females of one breast by either reducing or enlarging.

- Additional documentation Required:
  - History and physical findings
  - Height and weight
  - Size of each breast
  - Date of previous surgery, if applicable
  - Pathologic diagnosis, if applicable
  - Estimate of amount of tissue to be removed in a reduction or size of implant for augmentation.
  - Additionally, for those under 18 years of age, one of the following must be submitted as evidence of puberty completion.*

  *Evidence of puberty completion:*
  - Documented Tanner stage IV or V for members aged 15-18, **AND**
  - Stable height measurements for 6 months, **OR**
  - Puberty completion as shown on wrist radiograph.

- We consider the procedures **medically necessary** for any of the following
indications:
- Biological females must be at least 15 years of age and have reached puberty*, and have a diagnosis of Poland’s syndrome (congenital absence of breasts) OR
- A disfiguring traumatic accident (e.g. burn) or complication of medical treatment (e.g. necrosis) OR
- A breast infection resulting in disfigurement

We consider procedures for the following cosmetic and therefore not covered as a benefit exclusion:
- Unilateral augmentation or reduction mammoplasty intended to create symmetry between otherwise normal breasts and the medically necessary criteria above is not met OR
- Unilateral augmentation or reduction mammoplasty intended only to improve appearance or to improve a one’s self-esteem

Reference Resources


Related Policies

BCBSVT Medical Policy on Transgender Services
BCBSVT Medical Policy on Bioengineered Skin and Soft Tissue Substitutes

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer’s benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between
medical policy and contract/employer benefit plan language, the member’s contract/employer benefit plan language takes precedence

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>08/2016</td>
<td>New policy.</td>
</tr>
<tr>
<td>12/2016</td>
<td>Added CPT® Code 20926 for clarification in medical policy.</td>
</tr>
<tr>
<td>08/2017</td>
<td>Reviewed and voted at HPC 08/07/2017 with the following:</td>
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<tr>
<td></td>
<td>Updated related policies section, removed language under prophylactic</td>
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<tr>
<td></td>
<td>mastectomy section, added CPT® code 15777 as medically necessary,</td>
</tr>
<tr>
<td></td>
<td>removed language under breast reconstruction added additional medical</td>
</tr>
<tr>
<td></td>
<td>criteria under breast reconstruction, added coding table to align</td>
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<tr>
<td></td>
<td>with codes contained within the medical policy, removed language</td>
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<tr>
<td></td>
<td>under removal of implants, removed language under unilateral</td>
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<tr>
<td></td>
<td>breast surgery for asymmetry.</td>
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<tr>
<td>07/2018</td>
<td>Added CPT® code 15777 to require PA</td>
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</table>
11/2018  
Added HCPCS code C1789 & Q4122, to require prior authorization. HCPCS codes L2999, L3999, L5999 & L7499 removed from body of policy. Added related policy section.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors  
Date Approved

Joshua Plavin, MD, MPH, MBA  
Chief Medical Officer

Kate McIntosh, MD, FAAP  
Senior Medical Director

### Attachment I

CPT®/HCPCS Coding Table

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Brief Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT®</strong></td>
<td>11920</td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td><strong>CPT®</strong></td>
<td>11921</td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td><strong>CPT®</strong></td>
<td>11922</td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>Code Type</td>
<td>Number</td>
<td>Brief Description</td>
<td>Policy Instructions</td>
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</tr>
<tr>
<td>CPT®</td>
<td>15777</td>
<td>Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)(List separately in addition to code for primary procedure)</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19301</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19302</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19304</td>
<td>Mastectomy, subcutaneous</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19316</td>
<td>Mastopexy</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19318</td>
<td>Reduction mammaplasty</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19324</td>
<td>Mammaplasty, augmentation; without prosthetic implant</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19328</td>
<td>Removal of intact mammary implant</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19330</td>
<td>Removal of mammary implant material</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19342</td>
<td>Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19355</td>
<td>Correction of inverted nipples</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>Code Type</td>
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<tr>
<td>CPT®</td>
<td>19357</td>
<td>Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19361</td>
<td>Breast reconstruction with latissimus dorsi flap, without prosthetic implant</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19364</td>
<td>Breast reconstruction with free flap</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19366</td>
<td>Breast reconstruction with other technique</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19367</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19368</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19369</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19370</td>
<td>Open periprosthetic capsulotomy, breast</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>CPT®</td>
<td>19371</td>
<td>Preprosthetic capsulectomy, breast</td>
<td>Prior Approval Required</td>
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<tr>
<td>CPT®</td>
<td>19380</td>
<td>Revision of reconstructed breast</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>19396</td>
<td>Preparation of moulage for custom breast implant</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>CPT®</td>
<td>20926</td>
<td>Tissue grafts, other (eg, paratenon, fat, dermis)</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>C1789</td>
<td>Prosthesis, breast (implantable)</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>Code Type</td>
<td>Number</td>
<td>Brief Description</td>
<td>Policy Instructions</td>
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</tr>
<tr>
<td>HCPCS</td>
<td>L8020</td>
<td>Breast prosthesis, mastectomy form</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
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<tr>
<td>HCPCS</td>
<td>L8030</td>
<td>Breast prosthesis, silicone or equal, without integral adhesive</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
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<tr>
<td>HCPCS</td>
<td>L8031</td>
<td>Breast prosthesis, silicone or equal with integral adhesive</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
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<tr>
<td>HCPCS</td>
<td>L8039</td>
<td>Breast prosthesis, not otherwise specified</td>
<td>Prior Approval Required</td>
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<tr>
<td>HCPCS</td>
<td>L8499</td>
<td>Unlisted procedure for miscellaneous prosthetic services</td>
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<tr>
<td>HCPCS</td>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Q4100</td>
<td>Skin substitute, not otherwise specified</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Q4107</td>
<td>Graftjacket, per square centimeter</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Q4116</td>
<td>Alloderm, per square centimeter</td>
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</tr>
<tr>
<td>HCPCS</td>
<td>Q4122</td>
<td>DermACEll, per sq cm</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Q4128</td>
<td>FlexHD, Allopatch HD, or Matrix HD, per square centimeter</td>
<td>Prior Approval Required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S2066</td>
<td>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</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S2067</td>
<td>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</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S2068</td>
<td>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</td>
<td>Prior Approval Required unless billed with a diagnosis of breast cancer</td>
</tr>
<tr>
<td>Code Type</td>
<td>Number</td>
<td>Brief Description</td>
<td>Policy Instructions</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>donor site and shaping the flap into a breast, unilateral</td>
<td></td>
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</tbody>
</table>