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Breast Surgery and Breast Prosthesis Corporate Medical Policy

File Name: Breast Surgery
File Code: 7.01.VT22
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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. Blue Cross VT 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 individuals. Blue Cross VT 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 additionalinformation listed for a specific procedure as indicated for the specific procedures listed below

Blue Cross VT 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).

For services related to gender affirming surgeries refer to the Blue Cross VT Gender Affirming Services (Trans Services) Corporate Medical Policy.

Policy Guidelines

Breast Prosthetics (HCPCS codes, L8020*, L8030*, L8031*, L8032*, L8033*, L8039, L8499, L8699)

- Breast prosthetics are considered **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

- Breast prosthetics are considered **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.

- Mastectomy for gynecomastia is considered **medically necessary** for the following:
  - With a diagnosis of breast cancer; **OR**
  - When the criteria for a Prophylactic Mastectomy are met; **OR**
  - 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); **AND**
    - Additionally, for those under 18 years of age, the following must be submitted as 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.

- Mastectomy for gynecomastia is considered **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.

- Mastectomy for gynecomastia is considered **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.

Risk-Reducing (Prophylactic) Mastectomy (CPT® code 19303) – Surgical removal of breasts to reduce the risk of breast cancer occurrence. 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.

- Risk-reducing (prophylactic) mastectomy is considered **medically necessary** for any 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 (e.g., *PTEN*, *TP53*, *CDH1*, *STK11 or PALB2*); **OR**
    - Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or a first-degree relative with one of these syndromes; **OR**
    - Lobular carcinoma in situ; **OR**
    - Inflammatory breast cancer; **OR**

- History of radiotherapy to the chest between 10 and 30 years of age; **OR**
- Such extensive mammographic abnormalities that make biopsy or excision impossible; **OR**
- High risk of breast high risk (defined as lifetime risk of ≥20% of developing breast cancer) as identified by validated models that are largely defined by family history. One such example is the NIH National Cancer Institute Breast Cancer Risk Assessment Tool available at https://bcrisktool.cancer.gov/calculator.html

- Risk-reducing (prophylactic) mastectomy is considered **investigational** for all other indications, including, but not limited to contralateral prophylactic mastectomy in Individuals with breast cancer who do not meet criteria as defined above.

Breast Reconstruction (CPT® codes 15771, 15772, 15777, 19340*, 19342*, 19350*, 19357*, 19361*, 19364*, 19367*, 19368*, 19369*, 19380*). Utilization of natural or artificial tissue to reconstruct breasts following mastectomy, breast conservation therapy, burns, trauma and diagnostic deformity.

- Breast Reconstruction is considered **medically necessary** for any of the following:
  - For the affected breast
    - When breast tissue is affected by disease, trauma, burns or infection; **OR**
    - 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. Complication includes, but is not limited to abdominal scar revision/release related to prior tissue needed for breast reconstruction; **OR**
    - 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.

- Breast reconstruction following mastectomy for gynecomastia is considered **cosmetic and therefore not covered as a benefit exclusion.**

NOTE:

- Use of allogeneic acellular dermal matrix products including AlloDerm®, Cortiva® [AlloMax™], DermACELL™, FlexHD®, FlexHD® Pliable™ may be considered **medically necessary** when utilized as part of a medically necessary breast reconstruction approved per criteria above.
- Breast reconstruction utilizing autologous fat grafting as part of repair that meets **medical necessity** criteria above may be considered medically necessary and **requires prior approval.**
- The use of adipose-derived stem cells in autologous fat grafting to the breast is considered **investigational**.
- If the above 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 11921, 11922**)

Reduction Mammoplasty (CPT® code 19318*) – Surgical reduction of breasts in individuals due to size and persistent symptoms. May also be reported for breast surgery related to breast cancer treatment.

- Reduction Mammoplasty is considered **medically necessary** for the treatment of symptomatic macromastia for the following:
  - Breast size/cup has been stable for at least six consecutive calendar months prior to surgery; **AND**
  - The preoperative evaluation by the surgeon concludes that the amount of breast tissue removed will lead to reasonable prognosis of symptomatic relief; **AND**
  - Presence of one of more of the following:
    - Persistent well-documented symptoms which impair function, interfere with activities of daily or interfere with sleep. Such symptoms may include headache, pain at neck, shoulder, or back, are attributable to macromastia and there has been at least 3 months of one or more adequate conservative treatments. Such conservative treatments may include special support bras, NSAIDS, muscle relaxants, chiropractic care, and physical therapy; **OR**
    - Persistent or recurrent sub-mammary intertrigo or tissue ulceration attributable to macromastia that is unresponsive to adequate conservative treatment; **OR**
    - Thoracic outlet syndrome attributable to macromastia that has not been responsive to 3 months of adequate conservative treatments.
  - Additionally, for those under 18 years of age, the following must be submitted as 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.

NOTE: Medical records from the treating physician or other treating providers must be submitted to outline medical necessity criteria above.

- Reduction Mammaplasty is considered **medically necessary** for breast tissue rearrangement, at the time of or following lumpectomy or partial mastectomy for treatment of breast cancer.

- Reduction Mammoplasty is considered **cosmetic and therefore not covered as a benefit exclusion** for any of the following:
  - Performed in order to improve athletic performance
  - Obtained only to improve appearance or to improve one's self-esteem

- Reduction Mammoplasty is considered **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 surgical removal of breast implants

- Removal of a silicone gel-filled breast implant may be considered **medically necessary** for any of the following indications:
    - A documented implant rupture; **OR**
    - In cases of infection; **OR**
    - Extrusion of implant through the skin; **OR**
    - Baker Class III Contracture. NOTE, this only applies to implants originally placed for reconstructive purposes; **OR**
    - Baker Class IV contracture; **OR**
    - Surgical treatment of cancer in the affected breast; **OR**
    - As part of a covered reconstructive surgery for the opposite breast

- Removal of a saline-filled breast implant may be considered **medically necessary** for any of the following indications:
    - A documented implant rupture. NOTE: this only applies to implants originally placed for reconstructive purposes; **OR**
    - Extrusion of implant through the skin; **OR**
    - Baker Class IV Contracture; **OR**
    - Surgical Treatment of cancer in the affected breast; **OR**
    - As part of a covered reconstructive surgery for the opposite breast

- The following is considered **not medically necessary:**
    - Removal of an implant when the originalreconstruction was for cosmetic reasons and the medical necessity criteria above are not met.
    - Removal of an implant when member has systemic symptoms attributed to connective tissue disease, autoimmune disease, etc.
    - Removal of an implant with Baker Class III Contracture or lower for cosmetic indications
    - Removal of ruptured saline implants for cosmetic indications
    - Removal of implants due to pain not related to contracture or rupture.

- The following is considered **cosmetic and therefore not covered as a benefit exclusion**:
    - Removal of implant only to approve appearance or to improve one's self-esteem

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

Baker Classification of breast contractures:	
Class I:	Augmented breast feels as soft as a normal breast
Class II:	Breast is less soft and the implant can be palpated but is not visible.
Class III:	Breast is firm, palpable and the implant (or its distortion) is visible
Class IV:	Breast is hard, painful, cold, tender and distorted

Unilateral Breast Surgery for Asymmetry: Reduction Mammoplasty (CPT® 15771, 15772 & 19318) and/or Augmentation Mammoplasty (CPT® code 19325)
- surgical reconstruction in females of one breast by either reducing or enlarging.

- Unilateral Breast Surgery for Asymmetry, Reduction Mammoplasty and/or Augmentation Mammoplasty is considered **medically necessary** for any of the following indications:
    - Biological females must be at least 15 years of age and have reached puberty (criteria below), 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; **AND**
    - Additionally, for those under 18 years of age, the following must be submitted as 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.

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.

- The following is considered **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
    - Unilateral augmentation or reduction mammoplasty intended only to improve appearance or to improve a one's self-esteem

Tattooing of the nipple and/or areola (CPT® codes 11920*, 11921*, 11922*) –
Tattoo application as part of Breast Reconstruction.

Tattooing of the nipple and/or areola is considered **medically necessary** when above criteria for Breast Reconstruction are met.

NOTE: Services may be provided by qualified providers or by licensed tattoo artists contracting with a qualified provider, however billing for services must be submitted by the qualified provider contracting with Blue Cross VT.

Tattoo Removal of the radiation oncology tattoo

- It is considered **medically necessary** to remove the radiation oncology tattoo when the tattoo was placed for purposes of treatment of breast cancer

Reference Resources

1. Blue Cross and Blue Shield Association. Medical Policy Reference Manual 7.01.13 Surgical Treatment of Bilateral Gynecomastia. Last reviewed: 3/2026. Accessed 10/2026.
2. Blue Cross and Blue Shield Association. Medical Policy Reference Manual 7.01.153 Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast. Last reviewed: 2/2026. Accessed 10/2026.
3. Blue Cross and Blue Shield Association. Medical Policy Reference Manual 7.01.09 Risk-Reducing Mastectomy. Last reviewed: 10/2026. Accessed 10/2026.
4. Blue Cross and Blue Shield Association. Medical Policy Reference Manual 7.01.21 Reduction Mastectomy for Breast-Related Symptoms. Last reviewed: 3/2026. Accessed 10/2026.
5. Blue Cross and Blue Shield Association. Medical Policy Reference Manual 7.01.113 - Bioengineered Skin and Soft Tissue Substitutes. Last reviewed: 6/2026. Accessed 10/2026.
6. Cuhaci, N., Polat, S.B., Evranos, B., Esroy, R. and Cakir, B. Gynecomastia: clinical evaluation and management. Indian Journal of Endocrinology and Metabolism. 2014 Mar- Apr; 18(2): 150-158.
7. Kerrigan, C.L., Collins, E.D., Kim, H.M., Schnurr, P.L., Cunningham, B. and Lowery, J. Reduction mammoplasty: defining medical necessity. Medical Decision Making. 2002 May- Jun; 22(3): 208-17.
8. UpToDate - Complications of reconstructive and aesthetic breast surgery. Literature review current through 10/2021. Accessed 1/2023.
9. UpToDate - Overview of Breast Reduction. Literature review current through 7/2025. Accessed 8/2025.
10. Wolfswinkel, B.S., Lemaine, V., Weathers, W. M., Chike-Obi, C.J, Xue, A.S. and Heller, L. Hyperplastic Breast Anomalies in the Female Adolescent Breast. Seminars in Plastic Surgery. 2013 Feb; 49-55.

Related Policies

Gender Affirming Services
Bioengineered Skin and Soft Tissue Substitutes, Amniotic Membrane and Amniotic Fluid

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) 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, Blue Cross VT 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

Blue Cross VT 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, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be 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 compete, 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

08/2016	New policy.
12/2016	Added CPT® Code 20926 for clarification in medical policy.

08/2017	Reviewed and voted at HPC 08/07/2017 with the following: Updated related policies section, removed language under prophylactic mastectomy section, added CPT® code 15777 as medically necessary, removed language under breast reconstruction added additional medical criteria under breast reconstruction, added coding table to align with codes contained within the medical policy, removed language under removal of implants, removed language under unilateral breast surgery for asymmetry.
07/2018	Added CPT® code 15777 to require PA
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.
11/2019	References Reviewed. Language regarding tattooing added. Adaptive Maintenance Changes Effective 01/01/2020: Removed codes 19304, 20926 codes were deleted. Added codes 15769, 15771, 15772, 15773, 15774, 21601, 21602, 21603 to require PA effective 01/01/2020. Updated codes 11920, 11921, 11922 as prior approval required unless with a billed with a diagnosis of breast cancer. Added code L8033 to coding table the code is currently on prior approval list. No changes to policy statements.
06/2020	Clarification of autologous fat grafting and adipose-derived stem cells in autologous fat grafting in breast reconstruction. No other change to policy statement.
01/2021	Adaptive Maintenance Updates: Deleted codes 19324 &19366 effective 01/01/2021. Codes revised effective 01/01/2021 per AM cycle: 19318, 19325, 19328, 19330, 19342, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380.
03/2021	Name change from Breast Surgery to Breast Surgery and Breast Prosthesis. Addition of L8032 & L8033. Listed prosthetics codes to not require PA if billed with a diagnosis of breast cancer.
04/2021	External input from network provider. Addition of medical necessity indication of breast tissue rearrangement, at the time of or following lumpectomy or partial mastectomy, for CPT 19318 (Reduction Mammoplasty.) No PA needed if billed with a diagnosis of breast cancer.
07/2021	Clarifying language added for ruptured silicone breast implants. Also, language added for use of allogeneic acellular dermal matrix products. Added section for Tattoo Removal for Radiation and Oncology as medically necessary. Reference updated.
03/2022	Policy Reviewed. References updated. Clarification to breast reduction criteria to include conservative treatment duration of 3 months. Clarification of risk-reducing mastectomy section. Formatting and minor language changes. Removed codes 19301, 19302 & 19303 from requiring prior approval.
03/2023	Policy Reviewed. Policy Statements unchanged. Minor formatting changes. References updated.
08/2024	Policy reviewed. Addition of indications for risk-reducing mastectomy. Minor formatting changes for clarity and consistency. References updated.

08/2025	Policy reviewed. Removal of Allomend and Graftjacket as medically necessary as these materials are not evaluated for indication of breast reconstruction. Minor formatting changes for clarity and consistency. References updated.
10/2026	Policy reviewed. No changes to policy statement. Minor formatting changes. References updated. Removed code Q4100 from coding table code deleted. Removed code Q4107 Graftjacket are not evaluated for indication of breast reconstruction.

Eligible providers

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

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Attachment I

CPT®/HCPCS Coding Table

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	Prior Approval Required unless billed with a diagnosis of breast cancer

Code Type	Number	Brief Description	Policy Instructions
CPT®	11922	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)	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)	Prior Approval Required
CPT®	15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Prior Approval Required
CPT®	15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Prior Approval Required
CPT®	15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Prior Approval Required
CPT®	15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Prior Approval Required
CPT®	15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)	Prior Approval Required
CPT®	19300	Mastectomy for gynecomastia	Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
CPT®	19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)	No Prior Approval Required
CPT®	19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	No Prior Approval Required
CPT®	19303	Mastectomy, simple, complete	No Prior Approval Required
CPT®	19316	Mastopexy	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19318	Breast reduction	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19325	Breast augmentation with implant	Prior Approval Required
CPT®	19328	Removal of intact breast implant	Prior Approval Required
CPT®	19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)	Prior Approval Required
CPT®	19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19342	Insertion or replacement of breast implant on separate day from mastectomy	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19350	Nipple/areola reconstruction	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19355	Correction of inverted nipples	Prior Approval Required
CPT®	19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19361	Breast reconstruction; with latissimus dorsi flap	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19364	Breast reconstruction; with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)	Prior Approval Required unless billed with a diagnosis of breast cancer

Code Type	Number	Brief Description	Policy Instructions
CPT®	19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	Prior Approval Required
CPT®	19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	Prior Approval Required
CPT®	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)	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	19396	Preparation of moulage for custom breast implant	Prior Approval Required unless billed with a diagnosis of breast cancer
CPT®	21601	Excision of chest wall tumor including rib(s)	Prior Approval Required
CPT®	21602	Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy	Prior Approval Required
CPT®	21603	Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy	Prior Approval Required
HCPCS	C1789	Prosthesis, breast (implantable)	Prior Approval Required unless billed with a diagnosis of breast cancer
HCPCS	L8020	Breast prosthesis, mastectomy form	Prior Approval Required unless billed with a diagnosis of breast cancer

Code Type	Number	Brief Description	Policy Instructions
HCPCS	L8030	Breast prosthesis, silicone or equal, without integral adhesive	Prior Approval Required unless billed with a diagnosis of breast cancer
HCPCS	L8031	Breast prosthesis, silicone or equal with integral adhesive	Prior Approval Required unless billed with a diagnosis of breast cancer
HCPCS	L8032	Nipple prosthesis, prefabricated, reusable, any material, any type, each	Prior Approval Required unless billed with a diagnosis of breast cancer
HCPCS	L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each	Prior Approval Required unless billed with a diagnosis of breast cancer
HCPCS	L8039	Breast prosthesis, not otherwise specified	Prior Approval Required
HCPCS	L8499	Unlisted procedure for miscellaneous prosthetic services	Prior Approval Required
HCPCS	L8699	Prosthetic implant, not otherwise specified	Prior Approval Required
HCPCS	Q4116	Alloderm, per square centimeter	Refer to Corporate Bioengineered Skin Medical Policy
HCPCS	Q4122	DermACELL, per sq cm	Refer to Corporate Bioengineered Skin Medical Policy
HCPCS	Q4128	FlexHD, Allopatch HD, or Matrix HD, per square centimeter	Refer to Corporate Bioengineered Skin Medical Policy
HCPCS	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	Prior Approval Required unless billed with a diagnosis of breast cancer

Code Type	Number	Brief Description	Policy Instructions
HCPCS	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	Prior Approval Required unless billed with a diagnosis of breast cancer
HCPCS	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	Prior Approval Required unless billed with a diagnosis of breast cancer