Policy Number	SUR716.011
Policy Effective Date	06/15/2024

Reconstructive Breast Surgery

Table of Contents
Coverage
Policy Guidelines
Description
Rationale
Coding
References
Policy History

Related Policies (if applicable)
SUR716.001: Cosmetic and Reconstructive Procedures
SUR716.009: Breast Implant, Removal and/or Insertion
SUR716.010: Mastopexy
SUR716.012: Reduction Mammaplasty
SUR716.015: Risk-Reducing (Prophylactic) Mastectomy
SUR716.021: Adipose-Derived Stem-Cells in Autologous Fat Grafting to the Breast
SUR717.001: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0123 (IL HB 1384) Coverage for Reconstructive Services requires the following policies amended, delivered, issued, or renewed on or after January 1, 2025 (Individual and family PPO/HMO/POS; Student; Group [Small Group; Mid-Market; Large Group Fully Insured PPO/HMO/POS] or Medicaid), to provide coverage for medically necessary services that are intended to restore physical appearance on structures of the body damaged by trauma.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-99-405 related to coverage of mastectomy and reconstruction services, should an enrollee elect reconstruction after a mastectomy, requires coverage for surgery and reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and protheses and coverage for physical complications at all stages of a mastectomy, including lymphedema. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group,

HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

Coverage

This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.

Reconstructive breast surgery on the affected breast **may be considered medically necessary** following a full or partial mastectomy performed for disease, prophylaxis, accidental injury, or trauma.

Reconstructive breast surgery on the unaffected/contralateral breast **may be considered medically necessary** to achieve symmetry following a medically necessary full or partial mastectomy.

Reconstructive breast surgery techniques include, but are not limited to:

- Immediate or delayed insertion of breast implants, with or without associated expanders; AND/OR
- Autologous reconstruction using the patient's own tissues (e.g., latissimus dorsi flap, transverse rectus abdominis myocutaneous flap, thigh-based flaps [transverse upper gracilis/transverse myocutaneous gracilis, diagonal upper gracilis, profunda artery perforator, lateral thigh perforator, or superior gluteal artery perforator], or free flap); AND/OR
- Harvesting and grafting of autologous fat as a replacement (e.g., suction assisted lipectomy) for implants or to fill defects after breast conservation surgery; AND/OR
- Revision of reconstructed breast; AND/OR
- Reduction mammaplasty; AND/OR
- Mastopexy with or without breast implants; AND/OR
- Nipple/areola reconstruction and nipple tattooing.

Documentation Requirements: Documentation must accompany any request for benefits or claims filed for breast reconstruction following partial mastectomy procedures and shall include:

- History and physical examination notes; AND
- Confirmatory lab and pathology reports; AND
- Photo documentation of the breast profile.

NOTE 1: There is no time limit for coverage of reconstructive breast surgery procedure(s) following a medically necessary full or partial mastectomy.

NOTE 2: For associated policies related to reconstructive and contralateral mammaplasty (breast surgery) procedures or services, please see:

- SUR716.009 (Breast Implant, Removal and/or Insertion),
- SUR716.010 (Mastopexy),
- SUR716.012 (Reduction Mammaplasty), and/or
- SUR716.015 (Risk-Reducing (Prophylactic) Mastectomy).

NOTE 3: For the associated policy regarding suction-assisted lipectomy, please see SUR716.001, Cosmetic and Reconstructive Procedures.

NOTE 4: For the associated policy regarding liposuction, with or without ultrasound assistance, which is not the same service as suction-assisted lipectomy addressed in **NOTE 3**, please see SUR716.012, Reduction Mammaplasty.

NOTE 5: For the associated policy regarding utilization of stem-cells in fat grafting to the breast, please see SUR716.021, Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast.

Policy Guidelines

None.

Description

Reconstructive breast surgery is defined as a series of surgical procedures that is designed to restore the normal appearance of the breast after surgery, disease, accidental injury, or trauma. Breast reconstruction is distinguished from purely cosmetic procedures by the presence of a medical condition, e.g., breast cancer or trauma, which leads to the need for breast reconstruction.

Background

The most common indication for reconstructive breast surgery is a prior mastectomy; in fact, benefits for reconstructive breast surgery in these patients are a mandated benefit in many states.

In contrast, cosmetic breast surgery is defined as surgery designed to alter or enhance the appearance of a breast that has not undergone surgery, accidental injury, or trauma.

There is a broadening array of surgical approaches to breast reconstruction. The most common is insertion of a breast implant, either a silicone gel-filled or saline-filled prosthesis. The implant is either inserted immediately at the time of mastectomy or sometime afterward in conjunction with the previous use of a tissue expander.

For some patients, reconstructive mammaplasty is accomplished in several staged procedures requiring 2 or 3 operations. Multiple techniques including tissue expanders, breast implants, regional or distant autologous tissue transfers/flaps, and/or reconstruction of the nipple-areolar complex (and nipple tattooing if applicable) may be required. The following is a listing, with definitions, of breast "flap" reconstructive procedures:

1. Latissimus dorsi muscle flap utilizes donor tissue from the patient's back that can be employed for reconstruction without significant loss of function. The latissimus flap can be moved into the breast defect, still attached to its blood supply under the arm pit (axilla). The latissimus flap is usually used to recruit soft-tissue coverage over an underlying breast implant. There are instances where enough volume can be recruited to reconstruct small breast without the placement of a breast implant;
2. The abdominal flap used for breast reconstruction includes the TRAM (transverse rectus abdominis myocutaneous) flap, in which a portion of the abdomen tissue, including the skin, fat tissues, minor muscles, and connective tissues, is taken from the patient's abdomen and transplanted onto the breast site once the breast cancer has been surgically removed;
3. A DIEP (deep inferior epigastric perforators) flap is a type of breast reconstruction, in which abdominal muscle blood vessels, skin, and fat tissues are removed from the abdomen and transferred to the chest to reconstruct a breast without the sacrifice of any abdominal muscles; OR
4. The superficial inferior epigastric artery (SIEA) flap differs from the DIEP flap by utilizing tissue from the lower abdomen and takes a smaller section of skin and fat tissues to create the new breast. The blood vessels required for this flap come from the fatty tissue; OR
5. Thigh-based flaps (e.g., transverse upper gracilis/transverse myocutaneous gracilis [TUG/TMG], diagonal upper gracilis [DUG], profunda artery perforator [PAP], lateral thigh perforator [LTP], or superior gluteal artery perforator [SGAP]) are typically a secondary option for breast reconstruction because of concerns regarding limited tissue volume and donor-site morbidity. Generally, when the abdominal donor sites are not a viable option for a flap, thigh-based donor sites may fill the void and provide a reliable option.

Nipple areola reconstruction or nipple tattooing may also be considered reconstructive breast surgery.

Since the purpose of reconstructive breast surgery is to restore the normal appearance of the breast, on some occasions, procedures are performed on the contralateral, normal breast to achieve symmetry. Contralateral breast surgery, the modification of the opposite, unaffected breast, may include the following services:

- Reduction mammaplasty, a reconstruction of the breast to decrease in volume by excision of tissue;
- Mastopexy (with or without breast implants) or breast lift, a reconstruction performed to correct ptosis or drooping and sagging of the breast;
- Prophylactic mastectomy, not a procedure, per se; it is the rationale for the appropriateness to remove breast tissue in the absence of malignant disease and is also known as preventive mastectomy. It is typically bilateral, but may be performed unilaterally in a patient who has

previously undergone a mastectomy in the opposite breast for an invasive cancer and is at risk for developing cancer in the remaining breast; OR
- A combination of these procedures.

Frequently, additional surgical procedures are required to achieve the optimal final reconstructive results. These include excision of redundant tissue, repositioning of the implant, release of internal scar tissue, creation of inframammary fold, scar revision, and other tissue rearrangement.

The operative plan and specific techniques for breast reconstruction and contralateral breast surgery must be tailored to fit the patient's specific situation. This would include evaluating the terms of the cancer/pathology and the need for further treatment. Immediate reconstruction has the advantages of a shortened mastectomy incision, avoidance of mastectomy deformity, as well as multiple hospitalizations, multiple anesthesia, and postoperative courses. Delayed breast reconstruction following a mastectomy may be necessary when postoperative chemo- or radiation therapy is required. Reconstructive surgery may be performed immediately at the time of the initial surgery (mastectomy) or delayed for months or years.

The breast cancer management team includes, but is not limited to, the general, plastic or oncologic surgeon, radiologist, mammographer, radiation oncologist, medical oncologist, pathologist, breast-imaging specialist, nurses and nurse clinician, and medical social worker.

Regulatory Status
Reconstructive and contralateral mammaplasty are surgical procedures and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Rationale

This medical policy was originally developed in May 1990 and has been updated periodically using the PubMed database. The most recent literature review was performed through May 2, 2024.

Medical policies assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life (QoL), and ability to function--including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the

intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Most breast reconstruction patients are also breast cancer patients. Every year, a significant number of women with breast cancer must undergo mastectomy to treat their cancer effectively. Reconstructive breast surgery is considered medically necessary after a medically necessary mastectomy or after accidental injury or trauma. Except for medically necessary reduction mammaplasty (discussed in policy SUR716.012), these procedures would be considered cosmetic in other circumstances.

The evidence on breast reconstruction surgery consists primarily of case series, the majority of which are retrospective. A smaller number of prospective cohort studies have also been published. There is a lack of clinical trials, including a very limited number of RCTs. The main outcomes that are important in breast reconstruction research are the cosmetic result, measures of psychosocial functioning, and rates of procedure-related morbidity.

Numerous case series have demonstrated improvements in psychosocial functioning for women undergoing breast reconstruction following mastectomy. For example, in the Michigan Breast Reconstruction Outcomes Study (MBROS) (1), there were improvements in all subscales of the SF-36 health status questionnaire, and on the FACT-B scale, a breast-cancer specific health status instrument. These improvements were maintained for up to 2 years following surgery.

There is uncertainty in several areas of breast reconstruction. For women with breast cancer who are to receive radiotherapy post-mastectomy, the optimal timing and the preferred approach to breast reconstruction is controversial. Another important clinical question is the comparative effectiveness of different surgical approaches to reconstruction. The evidence for these 2 questions is reviewed below:

What is the Optimal Timing and Approach to Breast Reconstruction in Patients Receiving Radiotherapy Post-Mastectomy?

The potential advantages of immediate reconstruction are an improved cosmetic result and avoiding the need to operate later on irradiated tissue. On the other hand, complications of reconstruction are higher if immediate reconstruction is followed by radiotherapy. Radiotherapy post-reconstruction has been shown to be an independent predictor of contractures, fat necrosis, and poor cosmetic outcomes. (2) Delayed reconstruction avoids the problem of radiation complications in the reconstructed breast. The disadvantages of this

approach are the psychologic distress associated with waiting for reconstruction following mastectomy, and the difficulty of operating on previously irradiated tissue. (3, 4)

A Cochrane systematic review of immediate versus delayed breast reconstruction following mastectomy was published in 2011. (3) This review was confined to RCTs of immediate versus delayed surgery. Only 1 RCT from 1983 was identified, the results of which are probably not relevant to current clinical practice. As a result, no conclusions could be drawn on immediate versus delayed reconstruction.

Winters et al. (5) published a systematic review that focused on the health-related QoL outcomes following breast reconstruction surgery. These authors included articles that compared the outcomes of different types of reconstruction, or that compared immediate versus delayed reconstruction. They identified 2 RCTs, 11 prospective longitudinal studies, and 21 retrospective studies. The majority of the studies used general QoL instruments, such as the SF-36, rather than breast-specific QoL measures. The authors reported that the overall quality of the evidence was low. Most of the studies did not follow recommended methods for health-related QoL research, and there was a high degree of variability in the reported outcomes. Combined analysis was not performed due to variations in study methodology and outcomes. Conclusions from this systematic review were that limitations of methodology precluded any meaningful conclusions on whether immediate or delayed reconstruction is the preferred approach.

The MBROS (1) was a prospective longitudinal study from 12 centers, which followed patients who had undergone breast reconstruction following mastectomy for up to 2 years. The main outcomes that were evaluated were psychosocial measures, including the SF- (Short Form-) 36 Health Assessment and the Functional Assessment of Cancer Therapy – Breast (FACT-B). A total of 287 women completed baseline surveys, and 173 completed the 2-year follow-up for a response rate of 60.3%. The authors classified patients into the categories of immediate (n=116) versus delayed (n=57) reconstruction, and by the type of reconstructive surgery performed: pedicle transverse rectus abdominis myocutaneous (TRAM) flap (n=91), free TRAM (n=40), or expander/implant (n=42).

There was an improvement in QoL for all groups following reconstruction. At 2 years, the magnitude of improvement was greater for the immediate reconstruction group. Statistically significant improvements compared to baseline were noted for the SF-36 subscales of vitality, general mental health, role emotional, and social functioning; and for the FACT-B social well-being scale. In the delayed reconstruction group, there was a significant improvement in the FACT-B social well-being scale, but not for the subscales of the SF-36.

This study suggests that QoL outcomes may be better in immediate reconstruction versus delayed reconstruction. However, these conclusions are limited by the methodologic weaknesses of the study, which include a lack of formal comparisons between groups, a large number of dropouts at 2 years, and potential baseline differences in clinical characteristics of the groups that are compared.

Schaverien et al. (2024) conducted a RCT to evaluate outcomes in patients who received premastectomy radiotherapy (PreMRT) and regional nodal irradiation (RNI) followed by mastectomy and immediate breast reconstruction (IMBR). (7) Premastectomy radiotherapy is a new treatment sequence to avoid the adverse effects of radiotherapy on the final breast reconstruction while achieving the benefits of IMBR. Forty-nine patients were randomized to receive either hypofractionated (40.05 Gy/15 fractions) or conventionally fractionated (50 Gy/25 fractions) RNI. Forty-eight patients underwent mastectomy with IMBR, at a median of 23 days (IQR, 20-28.5 days) after radiotherapy. Forty-one patients had microvascular autologous flap reconstruction, 5 underwent latissimus dorsi pedicled flap reconstruction, and 2 had tissue expander placement. There were no complete autologous flap losses, and 1 patient underwent tissue expander explantation. Eight of 48 patients (17%) had mastectomy skin flap necrosis of the treated breast, of whom 1 underwent reoperation. During follow-up (median, 29.7 months [range, 10.1-65.2 months]), there were no locoregional recurrences or distant metastasis. This randomized clinical trial found PreMRT and RNI followed by mastectomy and microvascular autologous flap IMBR to be feasible and safe. Based on these results, a larger randomized clinical trial of hypofractionated vs conventionally fractionated PreMRT has been started (NCT05774678).

What is the Comparative Efficacy of Different Surgical Techniques for Breast Reconstruction?
There is a single RCT published comparing different techniques of breast reconstruction. (6) In this study, 87 women were randomized to 1 of 3 breast reconstruction techniques, and 75 women actually underwent 1 of the 3 procedures: Lateral thoracodorsal flap (n=16); Latissimus dorsi flap (n=30); or TRAM flap (n=29). At 6 months and 1 year following surgery, patients were asked about their satisfaction with the cosmetic result and the impact of the surgery on important areas of their lives. In addition, patients completed the SF-36 health status survey. At 6 months there were 56 responses (75%) to the survey and at 1 year there were 61 responses (81%). The majority of women reported a positive impact on major life areas and a positive change in overall health status. There were not significant differences among groups on any measure, except that the Latissimus dorsi group scored significantly lower on having problems with social situations compared to the other 2 groups. The results of this study support the conclusion that the benefit of breast reconstruction, in terms of cosmesis and QoL, is roughly equivalent across different surgical techniques.

In the Barry et al. (4) systematic review, the authors evaluated whether implant-based approach or an autologous tissue approach led to better outcomes in patients receiving radiotherapy. Of all patients receiving radiotherapy (n=380), 216 underwent implant-based reconstruction and 164 underwent autologous reconstruction. There was no significant difference in overall morbidity between those receiving implant-based reconstruction and those receiving autologous reconstruction (odds ratio [OR] 0.87, 95% confidence interval [CI] 0.47-1.62). However, for the subset of women who underwent both radiotherapy and immediate breast reconstruction, overall morbidity was less common in women undergoing autologous reconstruction (OR 0.20, 95% CI 0.11-0.39).

The MBROS (1) compared outcomes among patients. For most of the comparisons between types of surgeries, there were not significant differences noted. Patients who received delayed reconstruction with TRAM flap surgery had greater gains in body image compared with patients receiving implant-based reconstruction.

Summary of Evidence
For individuals who are undergoing breast reconstruction following mastectomy for breast cancer, or who have an accidental injury or trauma to the breasts, the evidence includes retrospective case series and cohort studies. Relevant outcomes are the achievement of symmetry and functional outcomes. For the general population of women undergoing mastectomy, the evidence supports the conclusion that breast reconstruction improves psychosocial outcomes, such as anxiety, social functioning, and perception of body image. These outcomes are achieved with acceptable complication rates. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are undergoing breast reconstruction following mastectomy and radiotherapy, particularly the optimal timing of reconstruction, the evidence includes a single randomized controlled trial and a systematic review. Relevant outcomes are the achievement of symmetry and functional outcomes. The evidence is sufficient to determine the comparative efficacy of different procedures and the timing of such, whether reconstruction should be immediate or delayed. Additionally, there is some evidence that an autologous tissue approach leads to better cosmetic outcomes in patients receiving radiotherapy. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Practice Guidelines and Position Statements
National Comprehensive Cancer Network (NCCN)
The NCCN guidelines on invasive breast cancer (V4.2024) (8) did not produce formal guidelines concerning breast reconstruction; however, they included a section titled “Principles of Breast Reconstruction Following Surgery”. The following general principles of breast reconstruction were included:

- “Breast reconstruction may be an option for any woman receiving surgical treatment for breast cancer. All patients undergoing breast cancer treatment should be educated about breast reconstructive options as adapted to their individual clinical situation. However, breast reconstruction should not interfere with the appropriate surgical management of the cancer or the scope of appropriate surgical treatment for this disease. Coordinating consultation and surgical treatment with a reconstructive surgeon should be executed within a reasonable time frame. The process of breast reconstruction should not govern the timing or the scope of appropriate surgical treatment for this disease. The availability of or the practicality of breast reconstruction should not result in the delay or refusal of appropriate surgical, medical and radiation intervention.”
- “Some patients may choose not to have reconstruction after mastectomy. The option to undergo mastectomy alone with a surgically optimized closure should be offered to all patients as part of a comprehensive discussion of reconstructive options. Achieving the

optimal result in this scenario may require additional procedures beyond the initial mastectomy."

- "Selection of reconstruction option is based on an assessment of cancer treatment, patient body habits, obesity, smoking history, comorbidities, and patient concerns. Smoking and obesity (WHO Class 2 and 3) increase the risk of preoperative complications for all types of breast reconstruction. Patients with these high-risk factors should be counseled about their increased risk for complications following breast reconstruction, including donor site complications/hernias and bulges of the abdominal wall, delayed healing, mastectomy skin flap necrosis, total flap failure (obesity), and implant failure (smoking)."
- "Nipple areolar reconstruction should be offered to patients if the nipple-areolar complex (NAC) has been removed as part of their cancer treatment. Various techniques are available for nipple reconstruction. Three-dimensional (3-D) tattooing can be offered to patients as an option for NAC reconstruction."
- "Additionally, women who are not satisfied with the cosmetic outcome following completion of breast cancer treatment should be offered a reconstructive surgery consultation."
- "Patients known to harbor genetic mutations that increase the risk of breast cancer may opt to undergo bilateral prophylactic mastectomies with reconstruction. Reconstruction can be performed with prosthetic, autologous tissue, or a combination of implant with autologous tissue."
- "Skin-sparing mastectomy should be performed by an experienced breast surgery team that works in a coordinated, multidisciplinary fashion to guide proper patient selection for skin-sparing mastectomy, determine optimal sequencing of the reconstructive procedure(s) in relation to adjuvant therapies, and perform a resection that achieves appropriate surgical margins."
- "Revisional surgery may be necessary after breast reconstruction. This may include procedures such as fat grafting, mastopexy, direct excision/suction-assisted lipectomy, contralateral procedures (in cases of unilateral reconstruction), and others. Patients should be informed before reconstruction that revision surgery may be necessary."

Ongoing and Unpublished Clinical Trials

Some currently ongoing and/or unpublished trials that might influence this policy are listed in Table 1.

Table 1. Summary of Key Trials

NCT Number	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT05774678	Trial Of PreoperAtive Radiation (TOPAz): A Randomized Trial Comparing Hypofractionated Versus Conventionally Fractionated Preoperative Radiation Followed by Mastectomy With	126	Nov 2028

	Immediate Autologous Breast Reconstruction With Integrated Nanomechanical Biomarker Evaluation		

NCT: national clinical trial

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	11920, 11921, 11922, 11970, 11971, 15734, 15756, 15757, 15769, 15771, 15772, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 19499, [Deleted 1/2021: 19324, 19366]
HCPCS Codes	C1789, L8031, L8032, L8039, L8600, S2066, S2067, S2068

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

References

1. Atisha D, Alderman AK, Lowery JC, et al. Prospective analysis of long-term psychosocial outcomes in breast reconstruction: two-year postoperative results from the Michigan Breast Reconstruction Outcomes Study. Ann Surg. Jun 2008; 247(6):1019-1028. PMID 18520230
2. Serletti JM, Fosnot J, Nelson JA, et al. Breast reconstruction after breast cancer. Plast Reconstr Surg. Jun 2011; 127(6):124e-135e. PMID 21617423
3. D'Souza N, Darmanin G, Fedorowicz Z. Immediate versus delayed reconstruction following surgery for breast cancer. Cochrane Database Syst Rev. Jul 6 2011; (7):CD008674. PMID 21735435
4. Barry M, Kell MR. Radiotherapy and breast reconstruction: a meta-analysis. Breast Cancer Res Treat. May 2011; 127(1):15-22. PMID 21336948
5. Winters ZE, Benson JR, Pusic AL. A systematic review of the clinical evidence to guide treatment recommendations in breast reconstruction based on patient-reported outcome measures and health-related quality of life. Ann Surg. Dec 2010; 252(6):929-942. PMID 20729711
6. Brandberg Y, Malm M, Blomqvist L. A prospective and randomized study, "SVEA," comparing effects of three methods for delayed breast reconstruction on quality of life, patient-defined problem areas of life, and cosmetic result. Plast Reconstr Surg. Jan 2000; 105(1):66-74; discussion 75-76. PMID 10626972

7. Schaverien MV, Singh P, Smith BD, et al. Premastectomy Radiotherapy and Immediate Breast Reconstruction: A Randomized Clinical Trial. JAMA Netw Open. April 1, 2024; 7(4):e245217. PMID 38578640
8. NCCN –Breast Cancer (Version 4.2024 – March 11, 2024). Published by the National Comprehensive Cancer Network. Available at <https://www.nccn.org> (accessed on May 2, 2024).
9. DOL – Your Rights After A Mastectomy. . . Women's Health & Cancer Rights Act of 1998 (WHCRA) (September 2018). Published by the U.S. Department of Labor. Available at <https://www.dol.gov> (accessed on May 2, 2024).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <http://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
06/15/2024	Document updated with literature review. Coverage unchanged. Reference 7 added; others updated.
07/15/2023	Reviewed. No changes.
01/15/2023	Document updated with literature review. Coverage unchanged. No new references added; updated reference 7.
10/01/2021	Reviewed. No changes.
02/15/2021	Document updated with literature review. Coverage section edited for clarity. No new references added; updated reference 7. Title changed from "Reconstructive and Contralateral Mammaplasty".
10/15/2019	Reviewed. No changes.
02/15/2019	Document updated with literature review. Coverage changed to include an example of autologous reconstruction using the patient's own tissues: thigh-based flaps; with a full explanation of thigh-based flaps in Description section. No references added or removed. 7/15/2017
07/15/2017	Reviewed. No changes.
05/15/2016	Document updated with literature review. Coverage unchanged.
11/01/2015	Reviewed. Clarification of full or partial mastectomy was included in each coverage statement. Reference to Reconstructive and Cosmetic Procedures, SUR716.001, was added as a NOTE to the coverage section.

01/15/2014	Document updated with literature review. The following was added to the list of breast reconstructive techniques for procedures to achieve symmetry as medically necessary: 1) immediate or delayed insertion of breast implants and with or without associated expanders; 2) autologous reconstruction using the patient's own tissues (e.g., latissimus dorsi flap, transverse rectus abdominis myocutaneous flap, or free flap); 3) harvesting and grafting of autologous fat as a replacement for implants or to fill defects after breast conservation surgery; 4) revision of reconstructed breast; and/or 5) nipple/areola reconstruction and nipple tattooing when the breast reconstruction is considered eligible for coverage. Rationale completely revised.
06/15/2008	Policy reviewed without literature review; new review date only.
01/01/2007	New CPT/HCPCS code(s) added.
04/15/2006	Revised/updated entire document.
01/01/2006	New CPT/HCPCS code(s) added.
07/01/2005	Revised/updated entire document.
11/01/2000	Revised/updated entire document.
05/01/1996	Medical policy number changed.
12/01/1995	Revised/updated entire document.
03/01/1991	Revised/updated entire document.
05/01/1990	New medical document.