WARNING:

- Breast implants are not considered lifetime devices. The longer people have them, the greater the chances are that they will develop complications, some of which will require more surgery.
- Breast implants have been associated with the development of a cancer of the immune system called breast implant-associated anaplastic large cell lymphoma (BIA-ALCL). This cancer occurs more commonly in patients with textured breast implants than smooth implants, although rates are not well defined. Some patients have died from BIA-ALCL.
- Patients receiving breast implants have reported a variety of systemic symptoms such as joint pain, muscle aches, confusion, chronic fatigue, autoimmune diseases and others. Individual patient risk for developing these symptoms has not been well established. Some patients report complete resolution of symptoms when the implants are removed without replacement.

The sale and distribution of Mentor Breast Implant Devices are restricted to users and/or user facilities that provide information to patients about the risks and benefits of the device prior to its use in the form and manner specified in approved labeling to be provided by Mentor Worldwide LLC.

2022
REIMBURSEMENT GUIDE
PHYSICIAN AND FACILITY

Mastectomy & Breast Reconstruction

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MASTECTOMY & BREAST RECONSTRUCTION

The Women's Health and Cancer Rights Act (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. Group health plans, insurance companies and health maintenance organizations offering mastectomy coverage must also provide coverage for all stages of reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment for physical complications of the mastectomy. Consult with the payer to determine coverage.

2022 Physician, Hospital Outpatient and ASC Medicare National Average Payments

MASTECTOMY		PHYSICIAN SERVICES	HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
CPT®	Description	Medicare Reimbursement[1]	SI	APC	Medicare Reimbursement[2]	PI	Medicare Reimbursement[2]
19300	Mastectomy for gynecomastia	$447	J1	5091	$3,225	A2	$1,206
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	$683	J1	5091	$3,225	A2	$1,206
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	$938	J1	5092	$5,652	A2	$2,309
19303	Mastectomy, simple, complete	$990	J1	5092	$5,652	A2	$2,309
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	$1,187	Not reimbursed by CMS in Outpatient or ASC				
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)	$1,266	Not reimbursed by CMS in Outpatient or ASC				
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	$1,221	J1	5092	$5,652	Not reimbursed by CMS in ASC	
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed	$141	N	N/A	Packaged	N1	Packaged[3]
C9756	Intraoperative near-infrared fluorescence lymphatic mapping of lymph node(s) (sentinel or tumor draining) with administration of indocyanine green (ICG) (list separately in addition to code for primary procedure)	N/A	N	N/A	Packaged	N1	Packaged[3]

RECONSTRUCTION		PHYSICIAN SERVICES	HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
CPT®	Description	Medicare Reimbursement[1]	SI	APC	Medicare Reimbursement[2]	PI	Medicare Reimbursement[2]
11970	Replacement of tissue expander with permanent prosthesis	$575	J1	5114	$6,397	J8	$3,888
11971	Removal of tissue expander(s) without insertion of prosthesis	$562	Q2	5073	$2,422	A2	$1,020
19325	Mammaplasty, augmentation; with prosthetic implant	$629	J1	5093	$9,106	G2	$2,855
19328	Removal of intact mammary implant	$568	Q2	5091	$3,225	A2	$1,206
19330	Removal of mammary implant material	$662	Q2	5091	$3,225	A2	$1,206
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	$777	J1	5092	$5,652	A2	$2,309
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	$779	J1	5093	$9,106	A2	$2,855
19350	Nipple/areola reconstruction	$689	J1	5091	$3,225	A2	$1,206
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	$1,188	J1	5094	$15,238	J8	$5,741
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	$1,594	Not reimbursed by CMS in Outpatient or ASC				
19364	Breast reconstruction with free flap	$2,785	Not reimbursed by CMS in Outpatient or ASC				
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	$1,811	Not reimbursed by CMS in Outpatient or ASC				
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	$2,222	Not reimbursed by CMS in Outpatient or ASC				
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	$2,065	Not reimbursed by CMS in Outpatient or ASC				
19370	Open periprosthetic capsulotomy, breast	$687	J1	5091	$3,225	A2	$3,225
19371	Periprosthetic capsulectomy, breast	$729	J1	5091	$3,225	A2	$3,225
19380	Revision of reconstructed breast	$826	J1	5092	$5,652	A2	$5,652
19396	Preparation of moulage for custom breast implant	$145	J1	5091	$3,225	G2	$3,225

FAT TRANSFER		PHYSICIAN SERVICES		HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
CPT®	Description	Medicare Reimbursement in Office[1]	Medicare Reimbursement Facility Setting[1]	SI	APC	Medicare Reimbursement[2]	PI	Medicare Reimbursement[2]
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	N/A	$490	T	5055	$3,596	G2	$1,824
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	$605	$505	T	5055	$3,596	G2	$1,824
+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)	$194	$150	N	N/A	N/A	N/A	N/A
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	$619	$518	T	5054	$1,749	G2	$887
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)	$190	$146	N	N/A	N/A	N/A	N/A

ICD-10-PCS CODES

Medicare uses The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS) codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-10-CM code, as well as any secondary diagnoses – some of which may be considered CCs or MCCs for MS-DRG assignment. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The circumstances of inpatient admission always govern the selection of principal diagnosis.

For patient admissions involving procedures, hospitals must also report ICD-10-PCS procedure code(s) for the surgical and other procedures as well as ICD-10-CM diagnosis codes. Listed below are the ICD-10-PCS procedure codes associated with common breast reconstruction procedures. Please determine the appropriate ICD-10-PCS code section based on the general descriptions in the right hand column. The first three characters outline the section, body system and operation. Once you have identified the section, the code can be coded to greater specificity by choosing the most appropriate body part, approach, device and qualifier within the brackets.

MASTECTOMY	
ICD-10-PCS Code	**Description**
07B[5,6]0ZZ	Excision of Axillary Lymphatic, Open Approach
07T[5,6]0ZZ	Resection of Axillary Lymphatic, Open Approach
07T[8,9]0ZZ	Resection of Internal Mammary Lymphatic, Open Approach
0HB[T,U,V]0ZZ	Excision of Breast, Open Approach
0HT[T,U,V]0ZZ	Resection of Breast, Open Approach
0KT[H,J]0ZZ	Resection of Thorax Muscle, Open Approach
RECONSTRUCTION	
ICD-10-PCS Code	**Description**
0H0[T,U,V]0JZ	Alteration of Breast with Synthetic Substitute, Open Approach
0HB[T,U,V]0ZZ	Excision of Breast, Open Approach
0HH[T,U,V]0NZ	Insertion of Tissue Expander into Breast, Open Approach
0HN[T,U,V]0ZZ	Release Breast, Open Approach
0HN[W,X]0ZZ	Release Nipple, Open Approach
0HP[T,U]0JZ	Removal of Synthetic Substitute from Breast, Open Approach
0HP[T,U]0NZ	Removal of Tissue Expander from Breast, Open Approach
0HQ[T,U,V]0ZZ	Repair Breast, Open Approach
0HQ[W,X]0ZZ	Repair Nipple, Open Approach

RECONSTRUCTION	
ICD-10-PCS Code	**Description**
0HR[T,U,V]0[7,J,K][5,6,7,8,9,Z]	Replacement of Breast using Flap, Non/Autologous Tissue Substitute, Synthetic Substitute, Open Approach
0HR[W,X]07Z	Replacement of Nipple with Autologous Tissue Substitute, Open Approach
0HR[W,X]X7Z	Replacement of Nipple with Autologous Tissue Substitute, External Approach
0HU[T,U,V]0JZ	Supplement Breast with Synthetic Substitute, Open Approach
0HW[T,U]0JZ	Revision of Synthetic Substitute in Breast, Open Approach
0JU60JZ	Supplement of Chest Subcutaneous Tissue and Fascia with Synthetic Substitute, Open Approach
0KX[F,G]0Z5	Transfer Trunk Muscle, Latissimus Dorsi Myocutaneous Flap, Open Approach
F0DZ8UZ	Prosthesis Device Fitting using Prosthesis
FAT TRANSFER	
ICD-10-PCS Code	**Description**
0HR[T,U,V]07Z	Replacement of Breast with Autologous Tissue Substitute, Open Approach
0HR[T,U,V]37Z	Replacement of Breast with Autologous Tissue Substitute, Percutaneous Approach
0HU[T,U,V]07Z	Supplement Breast with Autologous Tissue Substitute, Open Approach
0HU[T,U,V]37Z	Supplement Breast with Autologous Tissue Substitute, Percutaneous Approach
0JR607Z	Replacement of Chest Subcutaneous Tissue and Fascia with Autologous Tissue Substitute, Open Approach
0JR637Z	Replacement of Chest Subcutaneous Tissue and Fascia with Autologous Tissue Substitute, Percutaneous Approach
0JU607Z	Supplement of Chest Subcutaneous Tissue and Fascia with Autologous Tissue Substitute, Open Approach
0JU637Z	Supplement of Chest Subcutaneous Tissue and Fascia with Autologous Tissue Substitute, Percutaneous Approach

2022 Hospital Inpatient Medicare National Average Payments

MASTECTOMY / BREAST BIOPSY / OTHER BREAST PROCEDURES		HOSPITAL INPATIENT
MS-DRG	Description	Medicare Reimbursement[4]
582	Mastectomy for Malignancy with CC/MCC	$10,835
583	Mastectomy for Malignancy without CC/MCC	$10,165
584	Breast Biopsy, Local Excision and Other Breast Procedures with CC/MCC	$12,112
585	Breast Biopsy, Local Excision and Other Breast Procedures without CC/MCC	$11,471

CC = Complications and/or comorbidity
MCC = Major Complications and/or comorbidity

Supply Codes

BREAST IMPLANT / PROSTHESIS		HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
HCPCS CPT®	Description	SI	APC	Medicare Reimbursement[2]	PI	Medicare Reimbursement[2]
C1789	Prosthesis, breast (implantable)	N	N/A	Packaged	N1	Packaged
L8600	Implantable breast prosthesis, silicone or equal	N	N/A	Packaged	N1	Packaged

Notes:
- Medicare reimbursement for implants is packaged with the primary code
- Medicare: report C1789 for all types of implants
- Non-Medicare: report L8600 for all types of implants

SIZER / EXPANDER		HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
HCPCS CPT®	Description	SI	APC	Medicare Reimbursement[2]	PI	Medicare Reimbursement[2]
A4649	Surgical supply, miscellaneous	N	N/A	Packaged	N/A	N/A
99070	Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered	B	N/A	N/A	N/A	N/A

Notes:
- Medicare reimbursement for sizers and expanders is packaged with the primary code
- Medicare: report A4649
- Non-Medicare: report 99070
- There is no specific HCPCS code / C-code for breast sizers, tissue expanders or autologous fat grafts
- Tissue expanders are not considered implants since they are temporary until the breast prosthesis is implanted

Outpatient Hospital Status Indicators (SI):
B: Not paid under OPPS. J1: Hospital Part B services paid through a Comprehensive APC. Paid under OPPS; all covered Part B services on the same claim are packaged with the primary "J1" service for the claim, except services with OPPS SI = F, G, H, L and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19. **N:** Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment . **Q2:** Payment is packaged if billed on the same date of service as a HCPCS code assigned a status indicator "T"; otherwise payment is made through a separate APC payment. **T:** Procedure or Service, Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment.

Ambulatory Surgery Center (ASC) Payment Indicators (PI):
A2: Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight. **G2:** Non-office based procedure added in CY2008 or later; payment based on OPPS relative payment weight. **N1:** Packaged service/item; no separate payment made.

Sources:
[1] CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1751-F); Addendum B. All MPFS Fee Schedules calculated using CF of $33.5983 effective January 2022.
[2] CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-FC); Addendum B and Final ASC Addenda.
[3] Ibid.
[4] DRG values calculated using a base rate of $6,121.65 and Capital Standard Payment of $472.59. The national average hospital Medicare base rate is the sum of the full update labor-related and non-labor-related amount published in the Federal Register, FY 2022 IPPS Final Rule (CMS-1752-F2 and CMS-1762-F2) Table 5; Tables 1A, 1D.

FOR ADDITIONAL QUESTIONS OR INFORMATION PLEASE CONTACT MENTOR REIMBURSEMENT SUPPORT SERVICES AT: MENTORREIMBURSEMENTSUPPORT@ITS.JNJ.COM OR 1 (877) 260-0102

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