Policy Key: Mastectomy and Lumpectomy Procedures

TriWest Clinical Operations – TRICARE West Region

Scope

This Policy Key provides criteria to be used during medical necessity review of mastectomy and lumpectomy procedures.

For Active-Duty Service Members (ADSM) and TRICARE Prime Remote (TPR) beneficiaries, reviewers must first apply guidance outlined in TRICARE Operations Manual Chapter 17, Section 3, Supplemental Health Care Program (SHCP). If a service is excluded under ADSM/TPR provisions, no further policy review is required under this or any other Policy Key. [10]

Not Covered [1-5]

When it is determined that a cosmetic, reconstructive and/or plastic surgery procedure does not qualify for benefits, all related services and supplies are excluded, including any institutional costs. This includes the following:

- Cosmetic, reconstructive, and/or plastic surgery procedures performed primarily for psychological or psychiatric reasons or as a result of the aging process
- Augmentation or reduction mammoplasty, unless listed under the coverage criteria (including reconstructive breast surgery for incomplete or underdevelopment of breast not related to a verified congenital anomaly)
- Any procedure performed for personal reasons to improve the appearance of an obvious feature or a body part that would be considered by an average observer to be normal and acceptable for the patient's age and/or ethnic and/or racial background
- Revision of scars resulting from surgery and/or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery
- Cosmetic procedures performed as part of gender-affirming surgery
- Body contouring
- Face transplant, maxillary transplant, and facial Composite Tissue Allotransplantation (CTA)
- All services and supplies directly and indirectly related to surgical treatment (i.e., gender change), except when performed to correct ambiguous genitalia which was documented to have been present at birth
- Reduction mammoplasty solely to treat fibrocystic breast disease [6]
- Reduction mammoplasty sole for cosmetic reasons [6]
- All services and supplies directly and indirectly related to sex gender change and intersex surgery, except when performed to correct ambiguous genitalia [5]

Coverage Criteria

General Information

Benefits may be allowed for cosmetic, reconstructive, and/or plastic surgery, including otherwise covered services and supplies, for congenital anomalies and the conditions/indications listed under the coverage criteria. [1]

- Benefits are limited to those cosmetic, reconstructive, and/or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred.
    - There is an exception for authorized postmastectomy reconstructive breast surgery for which there is no time limitation between mastectomy and reconstruction.
    - Special consideration will be given to cases involving children who may require a growth period.

Note: Mastectomy may refer to complete, radical, modified radical, or partial (lumpectomy, tylectomy, quadrantectomy, segmentectomy) procedures, with or without axillary lymphadenectomy. [2]

Breast Reconstruction as a Result of a Congenital Anomaly [4]

Initial Level of Review may approve for **any** of the following:

- Amastia (absence of the breast); athelia (absence of nipple); polymastia (supernumerary breasts); polythelia (supernumerary nipples); tubular breast deformity; Poland syndrome
- Congenital hypoplasia of one breast and gigantomastia of the contralateral breast, if the breast reduction meets medical necessity criteria below
    - Paucity of breast tissue due to chest wall deformities
    - Augmentation and/or reduction of the collateral breast to correct congenital asymmetry when related to a congenital anomaly
    - Other congenital anomaly on a case-by-case basis

Note: A congenital anomaly may be present at birth but only manifest later (e.g., at puberty). In these cases, documentation (e.g., photographs, physical examination) to verify the anomaly may be required.

Gigantomastia of Pregnancy [4]

Initial Level of Review may approve for **any** of the following complications if delivery is not imminent.

- Massive infection
- Significant hemorrhage
- Tissue necrosis with sloughing
- Ulceration of breast tissue

Gynecomastia [5]

Initial Level of Review may approve the following:

Coverage criteria for surgical interventions may include, but is not limited to, severe gynecomastia (enlargement has not resolved after one year), fibrous tissue stroma exists, or breast pain.

Lumpectomy (Excisional Biopsy)/Partial Mastectomy [9]

Initial Level of Review may approve for**:**

- Lumpectomy (excisional biopsy) is indicated for **intraductal papilloma** for **any** of the following:
  - Core needle biopsy indicates atypia
  - Core needle biopsy indicates discordance between imaging and pathology results (one is suspicious for malignancy)
  - Size measuring greater than or equal to 1 cm
  - BI-RADS 4B/4C/5
- Lumpectomy for **fibroadenoma** for **any** of the following:
  - Rapid growth
  - Pain
  - Suspicion for phyllodes tumor
  - Suspicion for cancer
  - Cellular fibroepithelial lesions
- Partial mastectomy for **either** of the following:
  - Extensive disease
  - Malignancy

Post-Mastectomy Reconstructive Surgery [1,2,3]

Reconstruction consists of mound and nipple-areola reconstruction and nipple-areola tattooing following a medically necessary mastectomy (complete, radical, modified, or partial procedures such as lumpectomy with deformity or prophylactic mastectomy).

Note: Patient must have met TRICARE criteria for Mastectomy prior to a reconstruction being reviewed.

Initial Level of Review may approve **any** of the following:

- Contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammoplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy/lumpectomy reconstructed breast)
- Treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed, and complications that may result following symmetry surgery, removal and reinsertion of implants
- United States (US) Food and Drug Administration (FDA)-approved implant material and customized external breast prostheses

- Acellular allograft when used in a covered breast reconstruction surgery for women who have **any** of the following indications:
    - Insufficient tissue expander or implant coverage by the pectoralis major muscle, and additional coverage is required
    - Viable, but compromised or thin, post-mastectomy skin flaps that are at risk of dehiscence or necrosis
    - The infra-mammary fold and lateral mammary folds have been undermined during mastectomy and re-establishment of these landmarks are needed
- Harvesting (via of lipectomy or liposuction) and grafting of autologous fat as a replacement for implants for breast reconstruction, or to fill defects after breast conservation surgery or other reconstructive techniques

Note: External breast prosthesis in lieu of reconstructive surgery is covered under the Prosthetics Policy Key

Prophylactic Mastectomy or Lumpectomy [3, 11]

Note: Prophylactic mastectomies are also called risk-reducing surgeries. A high risk individual is one with a family history or personal history of cancer in the breast, and/or ovaries, or uterus; or personal history of cancer in the breast and/or ovaries or as otherwise defined by the National Comprehensive Cancer Center (NCCN) or the American College of Obstetricians and Gynecologists (ACOG), including individuals with a hereditary cancer syndrome. Carefully selected indications have been developed for prophylactic mastectomy and are included in this policy. For this section, where NCCN and ACOG guidelines differ, NCCN guidelines should take precedence.

Initial Level of Review may approve **any** of the following

- Prophylactic bilateral mastectomies are covered for patients who are at increased risk of developing breast carcinoma and have **one or more** of the following:
    - Atypical hyperplasia of lobular or ductal origin is confirmed on biopsy; or
    - A history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (Family Cancer Syndrome). A positive Breast Cancer (BRCA) genetic test is not necessary; or
    - One or more of the following pathogenic genetic mutations, when indicated by NCCN or ACOG recommendations, effective September 1, 2017: ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53; or
    - Chest wall radiation prior to 30 years of age, effective September 1, 2017; or
    - Any other clinical factor for which NCCN or ACOG recommend the consideration of a prophylactic bilateral mastectomy, effective September 1, 2017; or
    - Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with any of the above clinical presentations.
- Prophylactic contralateral mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with **any** of the following:
    - Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or

- Lobular carcinoma in-situ; or
- Large breast and/or ptotic, dense or disproportionately sized breast that is difficult to evaluate mammographically and clinically; or
- When observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or
- History of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (Hereditary Breast and Ovarian Cancer). A positive BRCA genetic test is **not** necessary; or
- One or more of the following pathogenic genetic mutations, when indicated by NCCN or ACOG recommendations, effective September 1, 2017: ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53; or
- Any other clinical factor for which NCCN or ACOG recommend the consideration of a prophylactic contralateral mastectomy, effective September 1, 2017.

Reduction Mammaplasty for Macromastia [4,6]

Initial Level of Review may approve if **all** the following are met:

- Reduction mammaplasty is covered when signs and symptoms of macromastia are functionally significant. Symptoms may include:
  - Postural backache
  - Upper back and neck pain
  - Ulnar paresthesia
  - Appropriate physical findings:
    - "True" hypertrophy
    - Shoulder grooving
    - Intertrigo
  - Poor posture
  - Inability to participate in normal physical activities
- **Apply Reduction Mammaplasty InterQual Criteria for final approval or denial.**

Silicone or Saline Breast Implant Removal (19328, 19330) [8]

Initial Level of Review may approve removal of silicone or saline breast implants for indications such as implant rupture or capsular contracture when **all** of the following criteria are met:

- Initial implantation **was or would have been a covered benefit**.
  - Example of covered benefits:
    - Cancer mastectomy reconstruction
    - Prophylactic mastectomy reconstruction
  - Example of non-covered procedure:
    - Elective, cosmetic augmentation (see NOTE below).
- Signs or symptoms of complications must be present and documented.

NOTE:

- If the initial silicone or saline breast implant surgery was for an indication not covered or coverable by TRICARE, implant removal may be covered **only** if it is necessary treatment of

a complication which represents a separate medical condition. Cases in which the FLR cannot confirm coverage shall be escalated to SLR.

- For **Breast Magnetic Resonance Imaging (MRI) to detect implant rupture**, refer to Diagnostic and Advanced Radiologic Imaging T-5 PK.

Definitions

Cosmetic, reconstructive, and/or plastic surgery is defined as surgery or treatments (including procedures, drugs, and devices) that can be expected to primarily improve the physical appearance of a beneficiary, and/or is performed primarily for psychological purposes, and/or restores form, but does not correct or materially improve a bodily function. [1]

Congenital anomaly is defined as a condition existing at or from birth that is considered a significant deviation from the common form or norm and is other than a common racial or ethnic feature. Two examples of congenital anomalies are cleft lip and syndactyly. Congenital anomalies do not include anomalies relating to teeth (including malocclusion or missing tooth buds) or structures supporting the teeth, or to any form of sex gender confusion (see 32 CFR 199.2(b) for full definition of congenital anomaly). [1]

Codes

CPT 55970, 55980

References

[1] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 2.1, Cosmetic, Reconstructive, and Plastic Surgery - General Guidelines.

[2] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 5.2, Post-Mastectomy Reconstructive Breast Surgery and Breast Prostheses.

[3] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 5.3, Post-Prophylactic Mastectomy, Prophylactic Oophorectomy, and Prophylactic Hysterectomy.

[4] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 5.6, Breast Reconstruction As A Result Of A Congenital Anomaly.

[5] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 15.1, Male Genital System.

[6] TRICARE Policy Manual 6010.63-M, April 2021, Change 41 (August 15, 2025), Chapter 4, Section 5.4, Reduction Mammaplasty For Macromastia.

[7] TRICARE Policy Manual 6010.63-M, April 2021, Change 4 (September 20, 2024) Chapter 4, Section 5.7, Gynecomastia.

[8] TRICARE Policy Manual 6010.63-M, Chapter 4, Section 5.5: Silicone Or Saline Breast Implant Removal. Retrieved September 02, 2025.

[9] NCCN Clinical Practice Guidelines In Oncology. Breast Cancer Screening and Diagnosis, version 2.2025, March 28, 2025.

[10] TRICARE Operations Manual (TOM) 6010.62-M, Chapter 17, Section 3: Supplemental Health Care Program (SHCP) Contractor Responsibilities, Retrieved 01/02/2026.

[11] TRICARE Policy Manual 6010.63-M, April 2021, Change 48 (March 17, 2026), Chapter 4, Section 5.3, Prophylactic Mastectomy, Prophylactic Oophorectomy, And Prophylactic Hysterectomy.