

Responses to Clinical Feedback on Breast Claims Rules (CR)

S/N	TOSP Code(s)	Feedback	MOH's Draft Reply
1	SA826B – Breast, tumour (malignant, various lesions), simple mastectomy, therapeutic/ prophylactic (4A)	Proposal for the term 'extensive' be added to "Multifocal/ multicentric pathologically proven B3 lesion – e.g. Lobular carcinoma in situ (LCIS)/ papillomatosis" and "lobular neoplasia" as this term is used interchangeably with LCIS.	The proposed change has been incorporated into the CR, under the indications for SA826B , as follows: "Multifocal/ multicentric/ extensive pathologically proven B3 lesion – e.g. Lobular carcinoma in situ (LCIS) or lobular neoplasia/ papillomatosis".
2	SA829B – Breast, various lesions, trucut biopsy (1A)	Suggestion for SA829B to be an inappropriate pair with: i. SA710B Breast, various lesions, trucut biopsy, ultrasound guided or stereotactic (single) (1B) and ii. SA709B Breast, various lesions, trucut biopsy, ultrasound guided or stereotactic (multiple) (1C)	The proposed change has been incorporated into the CR, under the inappropriate pairing list for SA829B .
3	SA821B – Breast, post prosthetic contraction, capsulotomy (unilateral) (3A)	Suggestion for guidelines around the minimum duration/ severity of symptoms for malpositioned implant.	The Claims Rules are not clinical practice guidelines but define the parameters of an appropriate MediShield Life claim. The CR does not seek to be overly prescriptive in the conditions justifying medical necessity for correction of malpositioned implants. Medical practitioners are expected to exercise good clinical judgement in determining the appropriate course of treatment.
4	<u>Breast reconstruction procedures</u>	Clarification was sought on whether the phrase 'breast reconstruction without limitation of duration' extends to fat grafting procedures (e.g. SA812F, SA813F, SA814F), given that reconstruction-related procedures may span several years.	The phrase "without limitation of duration" is only intended for delayed breast reconstruction. It also only applies to the specific breast reconstruction procedures stated in this CR. Fat grafting TOSP codes are not specifically addressed in this CR. As fat grafting is commonly performed as an adjunctive procedure in delayed breast reconstruction, the workgroup intentionally does not recommend imposing a time limit on the eligibility of these procedures for claims. Timing

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			and request for reconstruction is dependent on patient, and timing can vary by up to several years in many cases.
Queries on Appropriate TOSP Coding Practice			
5	<u>Chest wall perforator flap procedures</u>	Clarification was sought on the appropriate TOSP code to use for concurrent breast conserving surgery and chest wall perforator flap (i.e. LICAP, MICAP, AICAP) for breast cancer, including lateral intercostal artery perforator (LICAP), anterior intercostal artery perforator (AICAP), and thoracodorsal artery perforator (TDAP) flaps.	There are currently no specific TOSP codes for every type of flap. At present, flaps that do not have individual TOSP codes are coded according to their nature and complexity (e.g. local flaps, large regional flaps, and free flaps). As the variety of flap types and the corresponding table codes are difficult- and time-based, assigning specific anatomical codes for each flap type would unnecessarily increase the number of TOSP codes. The committee will however consider the inclusion of a general perforator flap code during the current TOSP review cycle.
6	<u>Targeted axillary dissection (TAD) procedures</u>	Clarification was sought on the appropriate TOSP code(s) for targeted axillary dissection (TAD) performed concurrently with breast cancer surgery.	This has been addressed in the Breast Claims Rules. Targeted axillary dissection (TAD) performed concurrently with breast cancer surgery may be claimed under the following TOSP codes: SA707B (4A) Wide excision/ lumpectomy/ segmental mastectomy/ partial mastectomy, with sentinel node biopsy/ axillary node sampling SA827B (4C) Simple mastectomy with sentinel node biopsy/ axillary node sampling SA834B (5A) Nipple/skin sparing mastectomy with sentinel node biopsy/ axillary node sampling
7	<u>Localisation of breast lesion/ lymph nodes prior to breast/ lymph nodes excision surgery</u>	Clarification was sought on appropriateness of a separate claim for preoperative imaging-guided localisation procedures (e.g. hookwire placement, clip marker insertion,	Preoperative localisation of breast tumours (e.g. hookwire/ clip marker/ wireless localiser) is considered part of the definitive breast procedure and is therefore not separately claimable. This applies regardless of the setting in which the localisation is performed, and the number of primary

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		wireless localiser deployment) performed in a separate room or on a separate day prior to surgery, including instances where the procedure is carried out by an interventional radiologist rather than the operating surgeon. Clarification was also sought on whether wire localisation fees are considered part of the breast excision TOSP benchmark regardless of setting and whether it is permissible to bill wire localisation separately without a TOSP e-filing in addition to the breast excision code.	surgeons involved in the surgery/ procedure. Only the definitive operation should be claimed, as detailed in the TOSP. The Claims Rules govern the appropriateness of MediShield Life claims but does not guide billing practices, which are institution-determined.
8	<u>Coding guidance on breast biopsies</u>	Two areas were raised regarding the coding guidance for vacuum-assisted biopsy (VAB) procedures, first, that ultrasound-guided, mammogram-guided, and MRI-guided VAB may each be clinically necessary within the same episode, as certain lesions are only detectable by specific imaging modalities. It was proposed that separate codes for different imaging-guided techniques should be permissible in such cases, rather than limiting submission to a single TOSP code. Secondly, the guidance to use the multiple TOSP code 'regardless of laterality' conflicts with the existing principle that two codes should be utilised for procedures performed on paired organs. It was proposed that 'regardless of laterality' be removed from the guidance, and that the appropriate single or multiple code be	The TOSP code to be submitted should be based on the biopsy technique employed, and not the imaging modality used. Any additional costs associated with specific imaging modalities are to be accounted for under separate billing components. Where different biopsy techniques are used within the same episode, separate codes for each technique may be submitted. On laterality, the coding guidance found in the consultation draft has been removed from the final Breast CR, with existing TOSP coding principles to apply pending the TOSP Review Committee's review of the feedback received. As this remains under review, any current allowance of such practice is interim in nature and may be subject to change following the conclusion of the review.

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		applied per breast where bilateral lesions are present.	
9	SA704B – Breast, lumps, imaging guided vacuum assisted biopsy, single lesion (2B) SA706B – Breast, lumps, imaging guided vacuum assisted biopsy, >1 lesion (2C)	Proposal for the creation of dedicated Table 3A and 3B codes for MRI-guided VAB procedures, noting that MRI-guided VAB is significantly more resource-intensive, technically complex, and time-consuming than ultrasound- or stereotactic-guided procedures, and may extend up to several hours for multiple lesions.	TOSP codes are intended to be approach- and modality-agnostic, the creation of dedicated MRI-guided VAB codes was not introduced in the current TOSP review cycle. This proposal may be considered at a future review.
10	SA833B – Breast, various lesions, nipple/ skin sparing/ subcutaneous mastectomy, therapeutic/ prophylactic, excluding gynaecomastia, unilateral (4C)	Clarification was sought on whether SA833B may be paired with other mastectomy codes (e.g. SA824B , SA825B , SA826B , SA827B) in cases where a gene mutation carrier presents with cancer in one breast, such that SA833B is used for the contralateral prophylactic mastectomy. It was further noted that the term 'prophylactic' in the descriptor for SA826B may be misleading in the context of malignant lesions. Confirmation was also sought that pairing of SA833B with SA833B is appropriate for cancer-free gene carriers undergoing bilateral prophylactic mastectomies.	The list of inappropriate pairings for Breast TOSP codes applies to procedures performed on the same lesion and the same breast, as indicated in the Breast CR. SA833B may be paired with the appropriate mastectomy code for the contralateral breast where clinically indicated, such as in gene mutation carriers undergoing concurrent therapeutic and prophylactic mastectomy. This feedback regarding the descriptor has been shared with the TOSP Review Committee for their consideration.

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11	SA822B – Breast, tumour (malignant), wide excision/lumpectomy/segmental mastectomy/ partial mastectomy (3C) SA823B – Breast, tumour (malignant), wide excision/lumpectomy/segmental mastectomy/ partial mastectomy, with axillary clearance, with/without sentinel node biopsy (4C) SA707B – Breast, tumour (malignant), wide excision/lumpectomy/segmental mastectomy/ partial mastectomy, with sentinel node biopsy/ axillary node sampling (4A)	Clarification was sought on whether, for patients undergoing breast conserving surgery with Level II mastopexy or reduction, the relevant lumpectomy codes (SA822B/SA823B/SA707B) may be submitted together with SA832B (Ipsilateral Mastopexy/Reduction Following Breast, Tumour (Malignant) Wide Excision/Lumpectomy/Segmental Or Partial Mastectomy, With Or Without Sentinel Node Biopsy And/Or Axillary Clearance) (4A).	Where breast surgery is performed with Level II mastopexy or reduction, the relevant TOSP code for lumpectomy may be submitted together with SA832B .
		Clarification was sought on whether, for patients undergoing breast conserving surgery with local tissue rearrangement procedures (e.g. crescent or doughnut mastopexy), the relevant lumpectomy codes (SA822B/SA823B/SA707B) may be submitted together with SA829S (Skin And Subcutaneous Tissue, Defect, Single Stage Local Flap (Simple/Small)) (3A), given that such procedures are not included under SA832B .	In line with the general guiding principle for reconstructive procedures in the TOSP booklet, local tissue rearrangement procedures that are not considered complex flap procedures should not be coded separately from the excision codes. Accordingly, the CR for SA832B has been amended to remove the statement permitting SA829S to be coded separately for local tissue rearrangement procedures. This feedback has been surfaced to the TOSP Review Committee for their consideration.
		Clarification was sought on whether the restriction against pairing the same TOSP code for the same lesion and same breast as applied to SA711B , similarly applies to SA707B , SA822B , and SA823B .	The proposed change has been incorporated into the CR, under the inappropriate pairing list for SA707B , SA822B and SA823B .
12	SA802B – Breast, diffuse hypertrophy, reduction	Feedback was received on the clinical criteria for breast reduction procedures, including the addition of criteria to guide assessment of medical necessity and corresponding specialist	The Claims Rules are not clinical practice guidelines but define the parameters of an appropriate MediShield Life claim. They are derived from clinical evidence and existing practices.

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	mammoplasty >500g (bilateral) (6A) SA803B – Breast, diffuse hypertrophy, reduction >250g (unilateral) (4B)	recommendations. It was further proposed that the 500g threshold for SA802B be reviewed, as this may not adequately account for body surface area, with the Schnur Sliding Scale suggested as a more objective measure of appropriate tissue removal. Respondents also noted the absence of a breast weight criterion for SA803B and sought clarification on whether a corresponding threshold applies.	There are numerous published evidence-based guidelines concluding that resection weight should not be the sole criterion for determining medical necessity. Whether using a fixed resection weight threshold (e.g. 250 g or 500 g) or the Schnur Sliding Scale, both approaches have inherent limitations and may disadvantage patients with certain body types. Clinical assessment and symptom severity should therefore remain the primary determinants of medical necessity. However, for the purpose of claims assessment, the committee recommends continuing to use the current resection weight thresholds as an objective administrative benchmark, while recognising its inherent limitations. On the feedback regarding SA803B, a surgical specimen weight requirement of 250g has been added to SA803B.
		Clarification was sought on whether reduction mammoplasty codes may be paired with flap repair codes.	Where wound closure, tissue approximation, and tissue rearrangement are steps inherent to reduction mammoplasty, they are considered part of the primary procedure and do not meet the threshold for a separate reconstruction or flap repair code.
13	SA831B Contralateral mastopexy/ reduction following breast, tumour (malignant) wide excision/lumpectomy/ segmental or partial mastectomy, with or without sentinel node biopsy and/or axillary clearance (4A) SA832B Ipsilateral mastopexy/ reduction following breast, tumour (malignant)	Clarification was sought on whether a reduction mammoplasty code may be submitted concurrently with a breast conserving procedure code for breast cancer and where breast reduction is performed on the contralateral breast only, whether the appropriate code to use is SA831B (Contralateral Mastopexy/ Reduction Following Breast Tumour (Malignant) Wide Excision/Lumpectomy/ Segmental Or Partial Mastectomy, With Or Without Sentinel Node Biopsy And/ Or Axillary Clearance).	Where mastopexy or reduction is performed in conjunction with breast surgery for breast carcinoma, SA831B Contralateral mastopexy/ reduction following breast, tumour (malignant) wide excision/lumpectomy/segmental or partial mastectomy, with or without sentinel node biopsy and/or axillary clearance (4A) or SA832B Ipsilateral mastopexy/ reduction following breast, tumour (malignant) wide excision/lumpectomy/segmental or partial mastectomy, with or without sentinel node biopsy and/or axillary clearance (4A)

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	wide excision/lumpectomy/ segmental or partial mastectomy, with or without sentinel node biopsy and/or axillary clearance (4A)		may be used.
14	SA707B – Breast, tumour (malignant), wide excision/ lumpectomy/ segmental mastectomy/ partial mastectomy, with sentinel node biopsy/ axillary node sampling (4A) SA827B – Breast, tumour (malignant, lesions), simple mastectomy with sentinel node biopsy/ axillary node sampling (4B)	Clarification was sought on whether an additional code may be submitted for extra lymph node biopsy where sentinel node biopsy is performed alongside other axillary node sampling on the same breast/ axilla, or whether the procedure should be captured under a single code such as SA707B or SA827B .	The relevant breast TOSP codes (e.g. SA707B, SA827B) are intended to cover sentinel lymph node biopsy (SLNB), axillary lymph node biopsy, and targeted axillary dissection (TAD) when performed in conjunction with an ipsilateral breast procedure. A separate additional code for extra lymph node biopsy on the same breast/axilla should not be submitted in such cases. Where axillary lymph node procedures are performed without a concurrent ipsilateral breast procedure, the following codes may be utilised: SE700L Lymph node (axillary), various lesions, radical excision/ clearance with or without sentinel lymph node biopsy (4A) SE701L Lymph node (axillary), various lesions, sentinel lymph node biopsy only (3A) SE800L Lymph node (axillary), various lesions, limited excision/biopsy (3A)
15	<u>Fat grafting procedures</u>	Clarification was sought on whether a fat grafting procedure code may be submitted concurrently with a breast reconstruction procedure code.	Fat grafting procedure codes may be submitted concurrently with a breast reconstruction procedure code when the fat grafting is performed as a distinct procedure and is not considered a standard component of the coded breast reconstruction procedure.

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Feedback on procedures not currently drafted in the Breast CR			
16	<u>Coding for acellular dermal matrix (ADM)/acellular dermis graft</u>	Clarification was sought on whether SA821S (Skin And Subcutaneous Tissue, Defect, Direct Flap (Cross Finger/ Similar Flaps)) (4A) may be used for acellular dermal matrix (ADM)/ acellular dermis graft procedures.	ADM is considered part of implant reconstruction and should be coded solely under <u>SA815B</u> (4A) <i>Breast, post mastectomy, implant/expander reconstruction/removal of implant, capsulectomy and replacement (unilateral)</i> . SA821S should not be submitted as an additional code for ADM placement.

Note: Feedback that was similar in nature has been grouped and addressed collectively. Not all individual submissions are displayed.