Priority Health	BILLING POLICY No. 155
External Breast Prostheses	
Date of origin: October 2025	**Review dates: September 2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards for External Breast Prostheses.

DEFINITION

An external breast prosthesis is a specially designed artificial form—often made of silicone or lightweight foam—worn outside the body, usually tucked into a bra, to recreate the natural contour of a breast following a mastectomy or lumpectomy.

MEDICAL POLICY

Breast Related Procedures - 91545 - reference for coverage details

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Frequency Specifics

Silicone breast prostheses have an expected useful lifetime of 2 years. Nipple prostheses are expected to last approximately 3 months, while fabric, foam, or fiber-filled breast prostheses typically have a 6-month lifespan. Replacements requested prior to these timeframes due to normal wear and tear will be considered noncovered and denied.

Coding specifics

- Code L8000 describes a bra designed with internal pockets to securely hold a breast prosthesis or mastectomy form against the chest wall. These bras do not contain an integrated prosthesis; for options that include built-in prosthetic elements, refer to codes L8001 and L8002. Items under L8000 may be made from any type of fabric—such as cotton, Lycra, polyester, or other materials—and are available in any size. They may also feature structural enhancements like underwire, though such support is not required.
- Codes L8001 and L8002 describe a bra featuring integrated breast prostheses—unilateral for L8001 and bilateral for L8002.
- Code L8015 describes a camisole-style undergarment featuring polyester fill, designed for post-mastectomy wear to provide gentle shaping and comfort during recovery.
- Code L8035 describes a molded-to-patient-model custom breast prosthesis, a specialized type of custom-fabricated device, created through a detailed process that begins with taking an impression of the patient's chest wall. This impression is used to produce a positive model, which serves as the foundation upon which the prosthesis is carefully molded to ensure a precise and personalized fit.

- Code A4280 should be reported when billing for an adhesive skin support designed to secure an external breast prosthesis directly to the chest wall.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- Use of the right (RT) and/or left (LT) modifiers is required when billing with these codes to indicate the applicable side of the body.
- When billing the same code for bilateral items provided on the same date of service, submit each item on separate claim lines using the RT (right) and LT (left) modifiers, with one unit of service per line.
- Do not combine RT and LT on a single claim line or bill two units of service on one line.
- Claims submitted without the appropriate RT and/or LT modifiers, or with both modifiers and two units on the same line, will be denied due to incorrect coding.

Note: Bras and other inherently bilateral items (codes L8000–L8002, L8015) are excluded from this RT/LT modifier requirement.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52478&ver=24

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan

Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
12/16/2025	Policy Effective
09/01/2026	Reviewed, no updates