How a medical recoding may limit cancer patients' options for breast reconstruction

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The federal government is reconsidering a decision that breast cancer patients, plastic surgeons, and members of Congress have protested would limit women's options for reconstructive surgery.

On June 1, the Centers for Medicare & Medicaid Services plans to reexamine how doctors are paid for a type of breast reconstruction known as DIEP flap, in which skin, fat, and blood vessels are harvested from a woman's abdomen to create a new breast.

The procedure offers potential advantages over implants and operations that take muscle from the abdomen. But it's also more expensive. If patients go outside an insurance network for the operation, it can cost more than $50,000. Furthermore, if insurers pay significantly less for the surgery as a result of the government's decision, some in-network surgeons would stop offering it, a plastic surgeons group has argued.

The DIEP flap controversy, spotlighted by CBS News in January, illustrates arcane and indirect ways the federal government can influence which medical options are available—even to people with private insurance. Often, the answers come down to billing codes—which identify specific medical services on forms doctors submit for reimbursement—and the competing pleas of groups whose interests are riding on them.

Medical coding is the backbone for "how business gets done in medicine," said Karen Joynt Maddox, a physician at Washington University School of Medicine in St. Louis who researches health economics and policy.

CMS, the agency overseeing Medicare and Medicaid, maintains a list of codes representing thousands of medical services and products. It regularly evaluates whether to add codes or revise or remove existing ones. Last year, it decided to eliminate a code that has enabled doctors to collect much more money for DIEP flap operations than for simpler types of breast reconstruction.

In 2006, CMS established an "S" code—S2068—for what was then a

relatively new procedure: breast reconstructions with deep inferior epigastric perforator flap, or DIEP flap. S codes temporarily fill gaps in a parallel system of billing codes known as CPT codes, which are maintained by the American Medical Association, a physician group.

Codes don't dictate the amounts private insurers pay for medical services; those reimbursements are generally worked out between insurance companies and medical providers. However, using the narrowly targeted S code, doctors and hospitals have been able to distinguish DIEP flap surgeries, which require complex microsurgical skills, from other forms of breast reconstruction that take less time to perform and generally yield lower insurance reimbursements.

CMS announced in 2022 that it planned to eliminate the S code at the end of 2024—a move some doctors say would slash the amount surgeons are paid. (To be precise, CMS announced it would eliminate a series of three S codes for similar procedures, but some of the more outspoken critics have focused on one of them, S2068.) The agency's decision is already changing the landscape of reconstructive surgery and creating anxiety for breast cancer patients.

Kate Getz, a single mother in Morton, Illinois, learned she had cancer in January at age 30. As she grappled with her diagnosis, she said, it was overwhelming to think about what her body would look like over the long term. She pictured herself getting married one day and wondered "how on earth I would be able to wear a wedding dress with only having one breast left," she said.

She thought a DIEP flap was her best option and worried about having to undergo repeated surgeries if she got implants instead. Implants generally need to be replaced every 10 years or so. But after she spent more than a month trying to get answers about how her DIEP flap surgery would be covered, Getz's insurer, Cigna, informed her it would

use a lower-paying CPT code to reimburse her physician, Getz said. As far as she could see, that would have made it impossible for Getz to obtain the surgery.

Paying out-of-pocket was "not even an option."

"I'm a single mom. We get by, right? But I'm not, not wealthy by any means," she said.

Cost is not necessarily the only hurdle patients seeking DIEP flaps must overcome. Citing the complexity of the procedure, Getz said, a local plastic surgeon told her it would be difficult for him to perform. She ended up traveling from Illinois to Texas for the surgery.

The government's plan to eliminate the three S codes was driven by the Blue Cross Blue Shield Association, a major lobbying organization for health insurance companies. In 2021, the group asked CMS to discontinue the codes, arguing that they were no longer needed because the American Medical Association had updated a CPT code to explicitly include DIEP flap surgery and the related operations, according to a CMS document.

For years, the American Medical Association advised doctors that the CPT code was appropriate for DIEP flap procedures. But after the government's decision, at least two major insurance companies told doctors they would no longer reimburse them under the higher-paying codes, prompting a backlash.

Physicians and advocacy groups for breast cancer patients, such as the nonprofit organization Susan G. Komen, have argued that many plastic surgeons would stop providing DIEP flap procedures for women with private insurance because they wouldn't get paid enough.

Lawmakers from both parties have asked the agency to keep the S code, including Rep. Debbie Wasserman Schultz (D-Fla.) and Sen. Amy Klobuchar (D-Minn.), who have had breast cancer, and Sen. Marsha Blackburn (R-Tenn.).

CMS at its June 1 meeting will consider whether to keep the three S codes or delay their expiration.

In a May 30 statement, Blue Cross Blue Shield Association spokesperson Kelly Parsons reiterated the organization's view that "there is no longer a need to keep the S codes."

In a profit-driven health care system, there's a tug of war over reimbursements between providers and insurance companies, often at the expense of patients, said Joynt Maddox, the Washington University physician.

"We're in this sort of constant battle" between hospital chains and insurance companies "about who's going to wield more power at the bargaining table," Joynt Maddox said. "And the clinical piece of that often gets lost, because it's not often the clinical benefit and the clinical priority and the patient centeredness that's at the middle of these conversations."

Elisabeth Potter, a plastic surgeon who specializes in DIEP flap surgeries, decided to perform Getz's surgery at whatever price Cigna would pay.

According to Fair Health, a nonprofit that provides information on health care costs, in Austin, Texas—where Potter is based—an insurer might pay an in-network doctor $9,323 for the surgery when it's billed using the CPT code and $18,037 under the S code. Those amounts are not averages; rather, Fair Health estimated that 80% of payment rates are

lower than or equal to those amounts.

Potter said her Cigna reimbursement "is significantly lower."

Weeks before her May surgery, Getz received big news—Cigna had reversed itself and would cover her surgery under the S code. It "felt like a real victory," she said.

But she still fears for other patients.

"I'm still asking these companies to do right by women," Getz said. "I'm still asking them to provide the procedures we need to reimburse them at rates where women have access to them regardless of their wealth."

In a statement for this article, Cigna spokesperson Justine Sessions said the insurer remains "committed to ensuring that our customers have affordable coverage and access to the full range of breast reconstruction procedures and to quality surgeons who perform these complex surgeries."

Medical costs that health insurers cover generally are passed along to consumers in the form of premiums, deductibles, and other out-of-pocket expenses.

For any type of breast reconstruction, there are benefits, risks, and trade-offs. A 2018 paper published in *JAMA Surgery* found that women who underwent DIEP flap surgery had higher odds of developing "reoperative complications" within two years than those who received artificial implants. However, DIEP flaps had lower odds of infection than implants.

Implants carry risks of additional surgery, pain, rupture, and even an uncommon type of immune system cancer.

Other flap procedures that take muscle from the abdomen can leave women with weakened abdominal walls and increase their risk of developing a hernia.

Academic research shows that insurance reimbursement affects which women can access DIEP flap breast reconstruction, creating a two-tiered system for private health insurance versus government programs like Medicare and Medicaid. Private insurance generally pays physicians more than government coverage, and Medicare doesn't use S codes.

Lynn Damitz, a physician and board vice president of health policy and advocacy for the American Society of Plastic Surgeons, said the group supports continuing the S code temporarily or indefinitely. If reimbursements drop, some doctors won't perform DIEP flaps anymore, she said.

A study published in February found that of patients who used their own tissue for breast reconstruction, privately insured patients were more likely than publicly insured patients to receive DIEP flap reconstruction.

To Potter, that shows what will happen if private insurance payments plummet. "If you're a Medicare provider and you're not paid to do DIEP flaps, you never tell a patient that it's an option. You won't perform it," Potter said. "If you take private insurance and all of a sudden your reimbursement rate is cut from $15,000 down to $3,500, you're not going to do that surgery. And I'm not saying that that's the right thing to do, but that's what happens."