STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Nipple Tattooing
SRG-012

Iowa Medicaid Program:	Claims Pre-Pay	**Effective Date:**	5/14/2008
Revision Number:	7	**Last Rev Date:**	1/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	1/17/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	10/9/2015

Criteria

Claims pre-pay review is required.

Nipple tattooing may be medically necessary when **ALL** the following are met:

1. Mastectomy must have been performed due to breast cancer or the genetic risk as documented by genetic testing; **AND**
2. No previous nipple tattooing has occurred. If previous nipple tattooing has occurred, further peer review is required.

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

CPT	Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less.
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.00 sq cm.
11922	Each additional 20.0 sq cm, or part thereof list separately in addition to code for primary procedure.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Medicare NCD 140.2 for breast reconstruction following mastectomy. http://www.cms.gov/medicare-coverage-database/details.ncd-details.aspx?NCDid=64&ncdver=1&DocID=140.2&bc=gAAAAAgAAAAA&. Accessed August 18, 2014.

Women's Health and Cancer Rights Act (WHCRA). http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html. Accessed August 18, 2014.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
1/19/2024	CAC	Annual review.	7
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
1/20/2023	CAC	Annual review.	6
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
1/21/2022	CAC	Annual review. Formatting changes.	5
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
10/16/2020	CAC	Removed 12-month timeframe as criterion #1.	4
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
10/9/2015	Medical Director	Added clarifying wording in introduction and reference addendum.	3
Signature C. David Smith, MD			

Change Date	Changed By	Description of Change	Version
10/17/2014	CAC	Criterion #2 added "or genetic risk as documented by genetic testing".	2
Signature			

Change Date	Changed By	Description of Change	Version
10/17/2014	Medical Director	Formatting changes and addition of references.	1
Signature			