

7.01.153 Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast

Original Policy Date:	December 1, 2016	Effective Date:	March 1, 2024
Section:	7.0 Surgery	Page:	Page 1 of 10

Policy Statement

- I. The use of adipose-derived stem cells in autologous fat grafting to the breast is considered **investigational**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

This policy is not intended to address the use of fat grafting for breast surgery (see Rationale section). Standard fat grafting (alone) for breast surgery can be approved. This policy only applies to the separate harvesting, preparation and use of stem cells taken from fat (adipose-derived) and then used to try to enhance the success rate of standard fat grafting.

Coding

There is no specific CPT code for this procedure. However, one of the following CPT codes might be used:

- **15769:** Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
- **15771:** Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
- **15772:** Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
- **15773:** Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
- **15774:** Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
- **19380:** Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
- **19499:** Unlisted procedure, breast

Description

Following a mastectomy, patients often experience pain and irradiated skin; as an adjunct to reconstructive breast surgery, surgeons will sometimes graft autologous fat to the breast. Adipose-derived stem cells (ADSCs) have been proposed as a supplement to the fat graft in an attempt to improve graft survival; however, whether ADSCs play a role in tumorigenesis is still relatively unknown.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

In September 2006, Celution Cell Concentration System (Cytori Therapeutics; San Diego, CA) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process as a cell saver device. The system is cleared for the collection, concentration, washing, and reinfusion of a patient's cells for applications that may include, but are not limited to, cardiovascular, plastic and reconstructive, orthopedic, vascular, and urologic surgeries and procedures. In 2007, Cytori Therapeutics received the FDA 510(k) clearance to market the Autologous Fat Transfer system, which transfers a patient's own adipose tissue from one part of the patient's body to another. FDA product code: CAC.

Rationale

Background

Fat Grafting to the Breast

Autologous fat grafting to the breast has been proposed for indications that include breast augmentation following oncologic surgery. Grafting would be performed as an adjunct to reconstruction after mastectomy or lumpectomy, and it would be of benefit in the following areas: for contouring purposes, improving breast shape and volume; and for alleviating post-mastectomy pain syndrome (neuropathic pain) and irradiated skin (thereby reducing complication and failure rates of implant reconstruction). Variability in long-term results and oncologic concerns have limited application of autologous fat grafting in the breast.

This evidence review does not address the use of autologous fat tissue in aesthetic breast augmentation (i.e., cosmesis).

Adipose-Derived Stem Cells

Stem cell biology and the related field of regenerative medicine involve multipotent stem cells that exist within a variety of tissues, including bone marrow and adipose tissue. A single gram of adipose tissue yields approximately 5000 stem cells; this is 100 to 500 times the number of mesenchymal stem cells found in an equivalent amount of bone marrow.¹ Stem cells, because of their pluripotentiality and unlimited capacity for self-renewal, offer promise for tissue engineering and advances in reconstructive procedures. In particular, adipose tissue represents an abundant and easily accessible source of adipose-derived stem cells (ADSCs), which can differentiate along multiple mesodermal lineages. ADSCs may allow for improved graft survival and the generation of new fat tissue after transfer from another site.^{1,2}

The potentially therapeutic properties of ADSC have led to novel techniques of fat grafting in conjunction with ADSC therapy for breast fat grafting. Differentiation of ADSC into adipocytes may provide a reservoir for adipose tissue turnover. Differentiation of ADSC into endothelial cells, with the release of angiogenic growth factors by ADSC, may decrease the rate of graft resorption by

increasing blood supply to the grafted fat tissue. Further, ADSC may serve to accelerate wound healing and protect the graft from ischemia reperfusion injury.¹ Current methods for isolating ADSCs can involve various processes, which may include centrifugation and enzymatic techniques that rely on collagenase digestion-which, in turn, is followed by centrifugal separation to isolate the stem cells from primary adipocytes. Isolated ADSCs can be expanded in a monolayer on standard tissue culture plastic surfaces with a basal medium containing 10% fetal bovine serum.³ Newly developed culture conditions provide an environment in which the study of ADSCs can be done without the interference of animal serum and may also allow rapid expansion of autologous ADSCs in culture for use in human clinical trials. A standard expansion method has not yet been established.

To address the problems of unpredictability and low rates of fat graft survival, Yoshimura et al (2008) developed a technique known as cell-assisted lipotransfer, which produces autogenous fat rich in ADSCs.⁴ In cell-assisted lipotransfer, half of the lipoaspirate is centrifuged to obtain a fraction of concentrated ADSCs; meanwhile, the other half is washed, enzymatically digested, filtered, and spun down to an ADSC-rich pellet. The latter is then mixed with the former, converting a relatively ADSC-poor aspirated fat to ADSC-rich fat.

A point-of-care system is available for concentrating ADSC from mature fat. The Celution System is designed to transfer a patient's adipose tissue from one part of the body to another in the same surgical procedure.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Adipose-Derived Stem Cell Enrichment of Autologous Fat Grafts

Clinical Context and Therapy Purpose

The purpose of autologous fat grafting with adipose-derived stem cell (ADSC) enrichment in individuals with breast cancer who have undergone reconstructive surgery is to improve graft survival.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with breast cancer who have undergone reconstructive surgery and have received autologous fat grafting.

Interventions

The therapy being considered is ADSC enrichment of autologous fat grafting to the breast. Growth factors within the ADSC may promote neovascularization thereby increasing blood supply to the grafted fat tissue, which would decrease the rate of graft resorption, accelerate wound healing, and protect the graft from reperfusion injury.

Comparators

The comparator of interest is autologous fat grafting to the breast without ADSC.

Outcomes

Absorption of the fat graft can be assessed after a few months. Long-term effects of the ADSC enhancement may not manifest for months to years following the procedure.

Due to the heterogeneity in outcome reporting in studies of autologous fat grafting to the breast, an international committee of experts in both breast and plastic surgery specialties used a Delphi consensus exercise to develop a core set of outcomes for determining safety and efficacy for this intervention.⁵ Consensus was reached on 13 core outcomes within 6 domains:

- Oncologic outcomes: the rate of histologically confirmed locoregional cancer recurrence; the rate of distant cancer recurrence; and mortality rate
- Clinical outcomes: complications; and donor site morbidity
- Aesthetic and functional outcomes: surgeon assessment of volume, shape, symmetry, scarring, and improvements in skin quality; and ability to function and complete daily tasks (assessed by a validated instrument such as EQ-5D or BREAST-Q)
- Patient-reported outcomes: patient satisfaction (preferably assessed by BREAST-Q); and impact on quality of life
- Process outcomes: number of graft sessions needed to get optimal results; and readmission or unplanned surgery for any reason
- Radiological outcomes: incidence of radiological abnormalities; and the number of interferences with subsequent mammography scanings.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse effects, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

The literature on the use of fat grafting to the breast with the use of ADSCs consists only of retrospective and small prospective cohort studies, case series, and case reports. The following is a summary of the key literature to date, of the studies using fat grafting to the breast and case series using fat grafting to the breast with the supportive use of ADSCs.

Rigotti et al (2007) reported on the results of a pilot study assessing the presence and effectiveness of ADSCs in 20 consecutive patients undergoing therapy for adverse events of radiotherapy to the breast, chest wall or supraclavicular region, with severe symptoms or irreversible function damage (Late Effects Normal Tissues-Subjective, Objective, Management, Analytic [LENT-SOMA] scale grades 3 and 4).⁶ Patients' mean age was 51 years (range, 37 to 71 years). The rationale behind the study was that the ADSCs, which have been shown to secrete angiogenic and antiapoptotic factors and to differentiate into endothelial cells, could promote neovascularization in ischemic tissue (e.g.,

irradiated tissue). Targeted areas included the supraclavicular region, the anterior chest wall after mastectomy (with or without breast prosthesis), and breast after quadrantectomy. A lipoaspirate purification procedure was performed by centrifugation to remove a large part of the triglyceride portion of the tissue and to disrupt the cytoplasm of the mature adipocytes to favor their rapid clearance after injection. A stromal-vascular fraction was isolated by enzymatic digestion of extracellular matrix, centrifugation, and filtration, and the fractions were cultured for 2 to 3 weeks to obtain a homogenous cell population. To assess the presence of mesenchymal stem cells, the stromal-vascular fraction derived from the adipose tissue was cultured and characterized by flow cytometry. The number of procedures was 1 in 5 patients, 2 in 8, 3 in 6, and 6 in 1. Clinical follow-up varied between 18 months and 33 months (mean, 30 months). Clinical results after treatment with lipoaspirates were assessed by the LENT-SOMA scale, which is a common system used to assess the late effects of radiotherapy. The 11 patients, who were initially classified as LENT-SOMA grade 4 (irreversible functional damage), progressed to grade 0 (no symptoms), grade 1 and grade 2 in 4, 5, and 1 cases, respectively. In 1 case, no improvements were observed. In the 4 patients who had undergone mastectomy and had breast prostheses and areas of skin necrosis, the necrosis showed complete remission. In the group of 9 patients classified as LENT-SOMA grade 3, fibrosis, atrophy, and retraction progressed to grade 0 and grade 1 in 5 and 4 cases, respectively.

Yoshimura et al (2008) reported on the development of a novel strategy known as cell-assisted lipotransfer (CAL), in which autologous ADSCs are used in combination with lipoinjection.⁴ From 2003 to 2007, the group performed CAL in 70 patients. Of these patients, CAL was performed in the breast for 60 patients (8 of whom had had breast reconstruction after mastectomy); for the remaining patients, CAL was performed in the face or hip. The authors reported outcomes for 40 patients with healthy thoraxes and breasts who underwent CAL for purely cosmetic breast augmentation; patients who were undergoing breast reconstruction for an inborn anomaly or following a mastectomy were not included. Nineteen of the 40 patients had been followed for more than 6 months, with a maximum follow-up of 42 months. The authors observed that the transplanted adipose tissue was gradually absorbed during the first 2 postoperative months, and the breast volume showed a minimal change thereafter. Final breast volume showed augmentation by 100 to 200 mL after a mean fat amount of 270 mL was injected. The difference in breast circumference (defined as the chest circumference at the nipple minus the chest circumference at the inframammary fold) had increased in all cases by 4 cm to 8 cm at 6 months. Cyst formation or microcalcification was detected in 4 patients. The authors concluded that their preliminary results suggested CAL is effective and safe for soft tissue augmentation and superior to conventional lipoinjection, but that additional study was necessary to evaluate the efficacy of this technique further.

Pérez-Cano et al (2012) conducted a single-arm, prospective, multicenter clinical trial of 71 women who underwent breast-conserving surgery for breast cancer and autologous adipose-derived regenerative cell-enriched fat grafting for reconstruction of defects 150 mL or less, a Clinical Evaluation Of Adipose Derived Regenerative Cells In The Treatment Of Patients With BrEast Deformities Post Segmental Breast Resection (Lumpectomy) With Or Without Radiation Therapy (RESTORE-2 trial).⁷ Trial endpoints included patient and investigator satisfaction with functional and cosmetic results and improvement in overall breast deformity at 12 months after the procedure. Eligible female patients included women 18 to 75 years of age who presented with partial mastectomy defects and without breast prosthesis. The RESTORE-2 protocol allowed for up to 2 treatment sessions, and 24 patients elected to undergo a second procedure following the 6-month follow-up visit. Of the 67 patients treated, 50 reported satisfaction with treatment results through 12 months. Sixty-one patients underwent radiotherapy as part of their treatment; 2 patients did not receive radiation, and the status of radiation treatment was not known for the other 4 patients. Using the same metric, investigators reported satisfaction with 57 of 67 patients. There were no serious adverse events associated with the adipose-derived regenerative cell-enriched fat graft injection procedure. There were no reported local cancer recurrences. The investigators found the LENT-SOMA scale insufficiently sensitive to reflect the clinical improvements seen in the trial population adequately. Patients with LENT-SOMA grade 3 and 4 scores (most severe symptoms) were

excluded during screening (note: this may have contributed to the subtle LENT-SOMA score changes observed in the trial). The investigators reported improvement from baseline through 12 months in the degree of retraction or atrophy in 29 of 67 patients, while 34 patients had no change and 4 patients reported worse symptoms. Postradiation fibrosis at 12 months was reported as improved in 29 patients, while 35 patients had no change and 3 patients had worse symptoms. Management of atrophy was reported as improved in 17 patients, with 48 patients having no change and 2 patients reporting worse symptoms. Improvement in these measures was statistically significant. The authors concluded that future comparative studies are needed to determine the incremental benefit of adipose-derived regenerative cell-enriched fat grafting compared with traditional fat grafting in various clinical circumstances. The follow-up of the study was inadequate to conclude the long-term risk of cancer recurrence.

Jeon et al (2020) evaluated the efficacy of CAL on the fat graft retention rate in patients with volume deficit after undergoing autologous breast reconstruction following total mastectomy.⁸ This 12-month prospective study included 20 patients (20 breasts) between 2017 and 2019. Patients were divided into 2 groups: autologous fat graft without stromal-vascular fraction (i.e., without ADSC) or autologous fat graft with stromal-vascular fraction of ADSC. The retention rate of the fat graft was higher in the group with ADSC than in the group without at both postoperative 6 months (73.8% vs 62.2%; $p=.03$) and 12 months (65.4% vs 48.4%; $p=.03$). Based on a modified BREAST-Q questionnaire at 12 months, the group who received fat graft with ADSC reported higher patient satisfaction (49.4 points out of 55 compared to 44.2 points out of 55), although this was not statistically significant. Fat necrosis occurred in 1 patient each in both groups, however, locoregional recurrence was not observed in any patient during follow-up. The authors concluded that CAL with stromal-vascular fraction provided better outcomes in terms of volume retention compared to CAL without ADSC.

Section Summary: Autologous Fat Grafting to the Breast with Adipose-Derived Stem Cell Enrichment

Evidence for the use of autologous fat grafting to the breast with ADSC enrichment consists of cohort studies, case series, and case reports. The studies were heterogeneous in the patient selection, methods in harvesting stem cells, number of procedures, and outcomes measured. One small, prospective study (N=20 patients) found that the use of ADSC enrichment with autologous fat grafting over autologous fat grafting alone improved the retention rate of the fat graft postoperatively at 6 and 12 months. Larger clinical trials are needed to confirm this benefit.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Society for Aesthetic Plastic Surgery and American Society of Plastic Surgeons

In 2011, the American Society for Aesthetic Plastic Surgery and the American Society of Plastic Surgeons released a joint position statement on the use of stem cells in aesthetic surgery.⁹ Based on a systematic review of the peer-reviewed literature, the Societies concluded that while there is potential for the future use of stem cells in aesthetic surgical procedures, the scientific evidence and other data are very limited in terms of assessing the safety or efficacy of stem cell therapies in aesthetic medicine.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

No relevant ongoing clinical trials were identified as of November 2023.

References

1. Mizuno H, Hyakusoku H. Fat grafting to the breast and adipose-derived stem cells: recent scientific consensus and controversy. *Aesthet Surg J*. 2010; 30(3): 381-7. PMID 20601560
2. Wilson A, Butler PE, Seifalian AM. Adipose-derived stem cells for clinical applications: a review. *Cell Prolif*. Feb 2011; 44(1): 86-98. PMID 21199013
3. Sterodimas A, de Faria J, Nicaretta B, et al. Tissue engineering with adipose-derived stem cells (ADSCs): current and future applications. *J Plast Reconstr Aesthet Surg*. Nov 2010; 63(11): 1886-92. PMID 19969517
4. Yoshimura K, Sato K, Aoi N, et al. Cell-assisted lipotransfer for cosmetic breast augmentation: supportive use of adipose-derived stem/stromal cells. *Aesthetic Plast Surg*. Jan 2008; 32(1): 48-55; discussion 56-7. PMID 17763894
5. Agha RA, Pidgeon TE, Borrelli MR, et al. Validated Outcomes in the Grafting of Autologous Fat to the Breast: The VOGUE Study. Development of a Core Outcome Set for Research and Audit. *Plast Reconstr Surg*. May 2018; 141(5): 633e-638e. PMID 29697603
6. Rigotti G, Marchi A, Galiè M, et al. Clinical treatment of radiotherapy tissue damage by lipoaspirate transplant: a healing process mediated by adipose-derived adult stem cells. *Plast Reconstr Surg*. Apr 15 2007; 119(5): 1409-1422. PMID 17415234
7. Pérez-Cano R, Vranckx JJ, Lasso JM, et al. Prospective trial of adipose-derived regenerative cell (ADRC)-enriched fat grafting for partial mastectomy defects: the RESTORE-2 trial. *Eur J Surg Oncol*. May 2012; 38(5): 382-9. PMID 22425137
8. Jeon HJ, Choi DH, Lee JH, et al. A Prospective Study of the Efficacy of Cell-Assisted Lipotransfer with Stromal Vascular Fraction to Correct Contour Deformities of the Autologous Reconstructed Breast. *Aesthetic Plast Surg*. Jun 2021; 45(3): 853-863. PMID 32995982
9. Kamakura T, Ito K. Autologous cell-enriched fat grafting for breast augmentation. *Aesthetic Plast Surg*. Dec 2011; 35(6): 1022-30. PMID 21533662

Documentation for Clinical Review

- No records required

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
	15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
	15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
	19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
	19499	Unlisted procedure, breast
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/01/2016	BCBSA Medical Policy adoption
11/01/2017	Policy revision without position change
03/01/2018	Policy revision without position change
03/01/2019	Policy revision without position change
03/01/2020	Coding update
04/01/2020	Annual review. No change to policy statement. Literature review updated.
01/01/2021	Coding update
03/01/2021	Annual review. No change to policy statement. Literature review updated.
03/01/2022	Annual review. No change to policy statement. Policy guidelines and literature updated.
03/01/2023	Annual review. No change to policy statement. Literature review updated.
03/01/2024	Annual review. No change to policy statement. Literature review updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast 7.01.153</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. The use of adipose-derived stem cells in autologous fat grafting to the breast is considered investigational. 	<p>Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast 7.01.153</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. The use of adipose-derived stem cells in autologous fat grafting to the breast is considered investigational.