# Referral/Letter of Medical Necessity

Regarding: _____ DOB: _____

Dear _____

I am referring _____ to you for evaluation and treatment for areolar micropigmentation. This letter provides information about the patient's medical history, diagnosis and treatment rationale.

## Patient's History and Diagnosis

This patient was diagnosed with _____ in _____
She underwent _____ mastectomies. She is currently under my care for breast reconstruction.

**Diagnosis Codes (ICD-10):**

- Z42.1 Encounter for breast reconstruction following mastectomy
- Z90.13 Acquired absence of bilateral breast and nipples
- Z85.3 Personal history of malignant neoplasm of breast procedure

**CPT Codes:**

- 11921 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation, from 6.1 to 20.0sq cm
- 11922 x1 Each additional 20.0sq cm

## Treatment Rationale

The patient is now ready to proceed with bilateral nipple/areolar reconstruction. I believe this procedure will benefit the patient by recreating the look of her natural areolas. The Women's Health and Cancer Rights Act of 1998 states that the micropigmentation or tattooing of the nipple-areolar complex is medically necessary and a component of breast reconstruction. Since breast reconstruction is a covered benefit on this patient's insurance plan, this treatment is covered as well.

I hope you will find _____ a suitable candidate for areolar micropigmentation.

Thank you for your continued support of our breast reconstruction patients.

Provider's Name _____ Provider's NPI _____

Signature _____ Date _____

AdventHealth
Medical Group

265 East Rollins Street, Suite 5300
Orlando, FL 32804
407-821-3555 | 407-821-3556 FAX