1.0 Description of the Procedure

1.1 Mastectomy

Mastectomy is the surgical removal of all or of part of the breast. Mastectomy is usually performed for breast cancer.

1.2 Male Gynecomastia

Mastectomy for gynecomastia is the surgical removal of breast tissue from adult males. Male gynecomastia is the excessive development of the male mammary glands. During puberty, enlargement of the male breast is normal and is usually transient.

1.3 Prophylactic Mastectomy

Prophylactic mastectomy is the removal of the breast(s) to prevent development of cancer in those recipients considered to be at high-risk of developing or redeveloping breast cancer.

1.4 Reduction Mammoplasty

Reduction mammoplasty is surgery to remove substantial breast tissue, including the skin and glandular tissue to reduce the size of the breast.

1.5 Breast Reconstructive Surgery

Breast reconstructive surgery is performed following a mastectomy to establish symmetry between the two breasts and includes the surgical creation of a new breast mound, and the creation of a new nipple/areolar complex. Reconstructive breast surgery may also include reduction mammoplasty on the unaffected breast to establish symmetry. Breast implants are surgically placed in the area where natural breast tissue has been removed. Breast implants are also used for breast enlargement for primarily cosmetic reasons.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

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3.0 When the Procedure is Covered

3.1 Mastectomy

Mastectomy is covered when it is medically necessary to remove the breast tissue due to the following conditions:

- malignant neoplasm of the breast
- secondary malignant neoplasm of the breast
- carcinoma in situ of the breast

3.2 Mastectomy for Male Gynecomastia

Mastectomy for male gynecomastia is covered when the following criteria are met:

1. The recipient is over 18 years of age and has a history of gynecomastia for three years or more, **and**
2. The excessive tissue is glandular and not fatty tissue as confirmed by clinical exam, mammogram or tissue pathology, **and**
3. Other causes of gynecomastia have been ruled out such as obesity, adolescence and drug treatments (gynecomastia resolves with the discontinuation of the medication), **and**
4. The excessive breast tissue development is not caused by non covered therapies or illicit drug usage such as marijuana, anabolic steroids, etc. (gynecomastia resolves with the discontinuation of the illicit drug usage), **and**
5. The recipient is not more than 25 percent over the ideal weight for his height based on the Metropolitan Life Insurance tables, **and**
6. The recipient has a documented history of significant medical symptoms due to the gynecomastia that are not resolved by conservative treatments.

3.3 Prophylactic Mastectomy

Prophylactic mastectomy is covered when **two or more** of the following criteria are met:

1. maternal or paternal family history of breast cancer consistent with autosomal dominant inheritance (about half of the family members are affected)
2. immediate family history of breast cancer (mother, sister or daughter)
3. severe fibrocystic disease that interferes with the ability to read mammograms
4. breast biopsy indicates that the recipient is at high risk for breast cancer (atypical hyperplasia)
5. personal history of breast cancer (lobular or intraductal) in the contralateral breast or personal positive BrCA1 or BrCA2 genetic testing

3.4 Reduction Mammoplasty

Reduction mammoplasty is covered when the following criteria are met:

1. The recipient is 19 years of age or older, **and**
2. The recipient is not pregnant, **and**
3. The recipient has not delivered a child within the past 12 months, **and**
4. The recipient's weight for body configuration is not more than 25 percent over the ideal weight according to the Metropolitan Life Insurance tables, **and**
5. The recipient has debilitating symptoms solely due to the breast enlargement, evidenced by at least **two** of the following conditions documented in the medical record:
   a. symptomatic kyphosis and osteoarthritis of the cervical spine as documented on x-ray
   b. scoliosis of the thoracic spine greater than 15 degrees as documented by x-ray

c. a history of chronic back, shoulder or chest pain, which incapacitates her ability to perform any work or personal duties
d. chronic intertrigo with or without pigmentation changes, that is unresponsive to antibiotic and antifungal therapy
e. an axillary inlet syndrome with numbness and tingling that is specifically related to the enlarged breasts.

Reduction mammoplasty of the contralateral breast may also be performed as a part of reconstructive surgery after a breast has been surgically removed because of cancer (invasive or in-situ-carcinoma). See **Section 3.5**.

3.5 Breast Reconstructive Surgery

1. Breast reconstructive surgery of the affected breast and reduction mammoplasty of the contralateral breast are covered in association with the primary mastectomy procedure for the following conditions:
   - malignant neoplasm of the breast
   - secondary malignant neoplasm of the breast
   - carcinoma in situ of the breast
   - prophylactic mastectomy when the criteria listed in **Section 3.3** are met
2. Breast implants are covered when surgically placed in the area where the natural breast tissue has been removed for a medically necessary mastectomy.

4.0 When the Procedure is Not Covered

The N.C. Medicaid program does not cover breast surgeries when the criteria listed in **Section 3.0** are not met.

The N.C. Medicaid program does not cover:

- breast implants when used for breast enlargement for cosmetic purposes
- removal of mammary implants or mammary implant material for cosmetic purposes
- augmentation mammoplasty with or without prosthesis for cosmetic purposes
- correction of inverted nipples
- revision of reconstructed breast
- preparation of moulage for custom breast implants
- periprosthetic capsulotomy and periprosthetic capsulectomy procedures for cosmetic purposes

5.0 Requirements for and Limitations on Coverage

5.1 Mastectomy for Breast Cancer

Mastectomy for breast cancer does not require prior approval.

5.2 Mastectomy for Male Gynecomastia

Prior approval is required for mastectomy for male gynecomastia. The following medical documentation must be submitted with the completed prior approval form:

1. height (in inches), weight (in pounds), age and body frame
2. unclothed preoperative photographs from the chin to the waist (or lowest extent of breasts, if lower) including standing frontal and side views with arms straight down at the sides
3. medical documentation of objective signs and symptoms, prior medical management including the recipient's current medications and endocrine study results
4. a list of subjective symptoms caused by breast enlargement with supporting medical documentation of debilitating symptoms
5. evidence of exclusion of other medical problems that may cause or contribute to the debilitating symptoms
6. a certification statement on the prior approval form by the requesting surgeon regarding the amount of tissue anticipated to be removed from each breast

5.3 Prophylactic Mastectomy

Prophylactic mastectomy requires prior approval. The requesting physician must submit the following medical documentation with a completed prior approval request form:

1. history and physical
2. diagnoses
3. medical records to demonstrate the criteria from 3.4
4. plan of treatment

5.4 Reduction Mammoplasty

Reduction mammoplasty policy guidelines are as follows:

1. Reduction mammoplasty is limited to once per lifetime.
2. Unilateral reduction mammoplasty is covered in cases of congenital absence or loss of significant breast tissue of the contralateral breast subsequent to trauma or medically necessary (cancer or high cancer risk) mastectomy as described in **Section 3.5**.
3. Prior approval is required for reduction mammoplasty. The following medical documentation must be submitted with the completed prior approval form:
   a. Height (in inches), weight (in pounds), age and body frame.
   b. Unclothed preoperative photographs from the chin to the waist (or lowest extent of breasts, if lower) including standing frontal and side views with arms straight down at the sides.
   c. The measurement (in centimeters) from the suprasternal notch to each nipple. (Ptosis is one consideration in determination of medical necessity.)
   d. Documentation of debilitation symptoms. For example, certification of the inability to perform activities of daily living, interference with employment or employability or inability to perform household tasks (including documentation of compensatory arrangements when unable to perform such tasks).
   e. Medical documentation of the exclusion of other medical problems that may cause or contribute to head, neck, shoulder, or back pain (emotional/psychological, endocrinological, neurological or musculoskeletal).
   f. Medical documentation of prior conservative medical management such as physical therapy, medication, weight reduction, etc.

g. Evidence or certification of objective signs of medical necessity (e.g., kyphosis, lordosis, scoliosis, arthritis, intertrigo, axillary inlet syndrome, etc.).
h. A list and chronology of subjective symptoms.
i. A certification statement on the prior approval form by the requesting surgeon that the recipient has been informed that breast reduction may interfere with breast feeding in the future, destroy or impair sexual sensitivity of the breasts and nipples, and may cause other surgical complications such as necrosis of the nipple, hypertrophic scarring, and hematoma.
j. A certification statement on the prior approval form by the requesting surgeon of the intent to remove at least 500 grams of tissue from each breast. Pathology reports, including the weight in grams removed from each breast, may be requested in support of claims at the option of the reviewer.

5.5 Breast Reconstructive Surgery

5.5.1 Candidates for Surgery

The best candidates for breast reconstructive surgery are women whose cancer, as far as can be determined, seems to have been eliminated by mastectomy. It is understood that patients with known metastasis would not be candidates for reconstruction.

5.5.2 Prior Approval

Certain breast reconstructive procedures require prior approval. The requesting physician must submit the following medical documentation with a completed prior approval request form:

1. history and physical
2. diagnoses
3. signs and symptoms
4. treatment plan

5.5.3 Policy Guidelines for Breast Reconstruction Surgery

The policy guidelines for breast reconstructive surgery are as follows:

- Breast reconstruction including implant material, is limited to once per breast per lifetime.
- Removal of a mammary implant or mammary implant material is covered when medically necessary. Prior approval is required.
- Periprosthetic capsulotomy and periprosthetic capsulectomy procedures are covered when it is medically necessary to remove the fibrous scar tissue. These procedures require prior approval. For pain or situations such as visible distortion or malposition of an implant, the prior approval request and supporting documents must indicate medical necessity.
- If the reconstruction is to follow a prophylactic mastectomy, prior approval must be obtained.

6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this procedure may bill for this service.

7.0 Additional Requirements

FDA approved prosthetic implants must be utilized for breast reconstructive surgery. Breast implants must be used in accordance with all FDA requirements current at the time of the surgery. A statement signed by the surgeon, certifying that all FDA requirements for the implant have been met must be retained in the recipient's office medical record and must be available for review upon request.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in the Medicaid Managed Care programs.

8.1 Claim Type

Providers bill professional services on the CMS-1500 claim form.

8.2 Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

8.2.1 Mastectomy

Diagnosis codes that support medical necessity for mastectomy are as follows:

174.0-174.9	175 (cancer of male breast)
198.81	238.3 (neoplasm of uncertain behavior, breast)
233.0	

8.2.2 Mastectomy for Male Gynecomastia

The diagnosis code that supports medical necessity for mastectomy for gynecomastia is 611.1.

8.2.3 Prophylactic Mastectomy

The diagnosis codes that support medical necessity for prophylactic mastectomy surgery include V10.3 and V16.3.

8.2.4 Reduction Mammoplasty

The diagnosis code that supports medical necessity for reduction mammoplasty is 611.1.

8.2.5 Breast Reconstructive Surgery

Diagnosis codes that support medical necessity for breast reconstructive surgery are as follows:

174.0-174.9	198.81	233.0	238.3
V10.3	V16.3		

8.3 Procedure Codes

8.3.1 Mastectomy

CPT codes covered for medically necessary mastectomy are as follows:

19160	19162	19180	19182
19200	19220	19240	

8.3.2 Mastectomy for Male Gynecomastia

The CPT code covered for mastectomy for gynecomastia is 19140 with prior approval.

8.3.3 Prophylactic Mastectomy

CPT codes covered for prophylactic mastectomy are 19180 or 19182 with prior approval.

8.3.4 Reduction Mammoplasty

The CPT code covered for reduction mammoplasty is 19318 with prior approval.

8.3.5 Breast Reconstruction

CPT codes that do not require prior approval (except after prophylactic mastectomy) include:

19340	19342	19350	19357

CPT codes that require prior approval include:

19316	19318	19325	19328
19330	19361	19364	19366
19367	19368	19369	19370
19371			

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1999

Revision Information:

Date	Section Updated	Change
10/01/04	Section 1.0	The definition was modified to include reduction mammoplasty of the non-diseased breast to achieve symmetry following a medically necessary mastectomy; prophylactic mastectomy; and mastectomy for male gynecomastia.
10/01/04	Section 3.0	Coverage criteria for prophylactic mastectomy and mastectomy for male gynecomastia was added.
10/01/04	Section 3.3.5	Personal positive BrCA1 and BrCA2 genetic testing added.
10/01/04	Sections 3.5, 5.5, 8.3.5	Added information about reconstruction after prophylactic mastectomy.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.