



BREAST RELATED PROCEDURES*

Effective Date: November 1, 2008

Review Dates: 8/07, 8/08

Date of Origin: August 8, 2007

Status: Current

**This policy includes the following previously separate policies: Breast Implants Explantation, Breast MRI, Breast Reconstruction and Revision Following Surgery for Breast Cancer, Male Gynecomastia, Mastectomy for Intractable Breast Pain and Reduction Mammoplasty.*

Summary of Changes

Clarifications:

-

Deletions:

- Section II. F. 2, Pg. 10 – Criteria for Breast MRI removed as AIM’s Clinical Guideline for MRI of the Breast will now be used.

Additions:

- Section II. F. 2, Pg. 10 – Statement added regarding prior authorization requirement through AIM.

DESCRIPTION

This policy addresses breast surgery, including reconstruction and revision following breast cancer, gynecomastia and imaging. Policy 91478 Breast Ductal Lavage has been retired. For prophylactic mastectomy, please see medical policy Prophylactic Cancer Risk Reduction Surgery 91508.

I. TABLE OF CONTENTS:

A. Breast Implant Removal	page 1
B. Reduction Mammoplasty	page 2
C. Breast Reconstruction and Revision	page 7
D. Male Gynecomastia	page 8
E. Mastectomy for Intractable Breast Pain	page 9
F. Screening Mammography and Breast MRI	page 9

II. POLICY/CRITERIA

A. Breast Implant Removal

1. Removal of breast implants that were placed for reconstruction after mastectomy, injury, congenital asymmetry, or augmentation mammoplasty is a covered benefit for the following indications:
 - a. Implants with recurrent infection
 - b. Extruded implants
 - c. Baker Class IV Contracture, associated with severe pain, or

- d. Breast cancer, new or recurrent (mastectomy and lumpectomy can be done with an implant in place, however, if a breast malignancy is discovered and the surgeon has requested coverage for removal, it is appropriate to provide coverage).
- e. Implant rupture
2. Replacement/reinsertion of a breast implant is a covered benefit only if the original placement surgery would have been a covered benefit (e.g. if original prosthesis was placed due to cancer surgery, replacement of the prosthesis is a covered benefit; if original surgical indication was cosmetic augmentation, replacement of the prosthesis is not a covered benefit).
3. Removal of breast implants for the following conditions has been determined to not be medically necessary, and therefore, not a covered benefit:
 - a. Breast malposition/asymmetry
 - b. Baker Class II or III Contracture*
 - c. Patient anxiety related to the possibility of developing systemic disease, or anxiety related to the influence of breast implants on a current "autoimmune disease". It has not been proven that individuals with breast implants are at an increased risk of developing a systemic disease, or that the implants influence the current status of the systemic disease.
4. Pain is frequently cited an indication for removal. The requesting physician should supply clinical information related to the degree of contracture (Baker classification*), or describe the etiology of the pain.

* Various systems have been used to classify breast contractures, but the most commonly used is the Baker classification. Four grades are described as follows:

- Grade I** Augmented breast feels soft as a normal breast
- Grade II** Augmented breast is less soft and implant can be palpated, but is not visible
- Grade III** Augmented breast is firm, palpable and the implant (or distortion) is visible
- Grade IV** Augmented breast is hard, painful, cold, tender and distorted

B. Reduction Mammoplasty

Reduction mammoplasty is a covered benefit when performed for medical or functional reasons as defined below. Reduction mammoplasty is not a covered benefit when performed for cosmetic or aesthetic reasons.

Indications and coverage for reduction mammoplasty are as follows:

1. **Unilateral reduction mammoplasty** is a covered benefit for asymmetry for patients 18 years or older if either a. or b. below applies:

- a. Asymmetry resulting from reconstructive surgery for cancer on the contralateral breast if the member is currently receiving services related to the breast cancer. A reduction on the unaffected breast is not subject to the 50% co pay that applies to reduction mammoplasty unrelated to breast cancer.

OR

- b. **Both** of the following:
1. The patient has a symptom score greater than or equal to 3 based on the following:

	Severe	Moderate/Mild
• Digital (finger) paresthasias	3.0	1.5
• Occipital headaches	2.0	1.0
• Cervical lordosis, thoracic kyphosis, or neck pain	2.0	1.0
• Lumbar lordosis or low back pain	2.0	1.0
• Breast pain	1.0	0.5
• Grooves on shoulder from brassiere or shoulder pain	1.0	0.5
• Intertrigo: rash under breasts	1.0	0.5
• Asymmetry of the breast (>30% difference)	1.0	0.5

and

2. The operating surgeon documents that the estimated amount (in grams) of breast tissue to be removed or removed from the breast must be more than the minimum amount for a given body surface area (BSA) according to the Schnur Sliding scale, which is an evaluation method for physicians to use on individuals considering breast reduction surgery. The Schnur scale can be accessed at the following web site.

http://www.bcbst.com/MPManual/the_schnur_sliding_scale_chart.htm.

A reference example of the Schnur scale is also given below.

**Body surface area and cutoff weight
of average breast tissue removed**

Body Surface Area (m²)	<u>Average grams of tissue per breast to be removed</u>
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310

1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662

The body surface area (BSA) is calculated using a formula. There are many different formulas that give slightly different results for BSA. The following web site gives several different formulas, and a link to a calculator for them:

<http://www.halls.md/body-surface-area/refs.htm>.

However, for purposes of the Schnur Sliding Scale and this Policy, the following simplified formula is to be used: $(BSA \text{ (in m}^2) = [\text{height (cm)}]^{0.718} \times [\text{weight (kg)}]^{0.427} \times .007449)$. See website listed below for easy calculation:

<http://www.bcbst.com/providers/calculator.asp>

2. **Bilateral reduction mammoplasty** is a covered benefit when **all** of the following are met:
 - a. The patient has symptoms adversely affecting activities of daily living and quality of life due to severe back, neck, and/or shoulder pain or upper extremity paresthesias, that are directly attributable to macromastia, and that have not responded to conservative measures.
 - b. The operating surgeon documents that the estimated amount (in grams) of breast tissue to be removed or removed from **each** breast

must be more than the minimum amount for a given body surface area (BSA) according to the Schnur Sliding scale (see above).

- c. The patient is at least 18 years of age or breast growth is complete **and**
- d. PCP has referred patient.

3. **If the patient does not meet criteria for 2. above**, Priority Health requires **all** criteria for **Set a. OR Set b. below**:

Set a. **All** of the following:

- a. The patient is at least 18 years of age or breast growth is complete.
 - 1. Evaluation by a physiatrist who has determined that **both**:
 - i. The pain cannot be solely explained by a musculoskeletal condition (e.g., arthritis, spondylitis, acromioclavicular strain) **and**
 - ii. Reduction mammoplasty is likely to result in improvement of the chronic pain
 - 2. The patient has a symptom score greater than or equal to 3 based on the following:

	Severe	Moderate/Mild
• Digital (finger) paresthesias	3.0	1.5
• Occipital headaches	2.0	1.0
• Cervical lordosis, thoracic kyphosis, or neck pain	2.0	1.0
• Lumbar lordosis or low back pain	2.0	1.0
• Breast pain	1.0	0.5
• Grooves on shoulder from brassiere or shoulder pain	1.0	0.5
• Intertrigo: rash under breasts	1.0	0.5
• Asymmetry of the breast (>30% difference)	1.0	0.5

- b. **All** of the following:
 - 1. The patient is at least 18 years of age or breast growth is complete.
 - 2. Persistent pain and related symptoms despite at least a 6 month trial of therapeutic measures including **all** of the following:
 - i. Supportive devices (e.g., proper bra support/fitting, wide bra straps)
 - ii. Analgesic/NSAIDs
 - iii. One of the following: Chiropractic care/physical therapy/exercises/posturing maneuvers/osteopathic manipulation
 - 3. The patient has a symptom score greater than or equal to 3 based on the following:

	Severe	Moderate/Mild
• Digital (finger) paresthesias	3.0	1.5
• Occipital headaches	2.0	1.0
• Cervical lordosis, thoracic kyphosis, or neck pain	2.0	1.0

• Lumbar lordosis or low back pain	2.0	1.0
• Breast pain	1.0	0.5
• Grooves on shoulder from brassiere or shoulder pain	1.0	0.5
• Intertrigo: rash under breasts	1.0	0.5
• Asymmetry of the breast (>30% difference)	1.0	0.5

4. The following are covered benefits:
 - a. Treatment for complications of reduction mammoplasty including cellulitis, other infections, and lymphedema.
 - b. Revisions required by surgical complications including infection, hematoma or seroma, or skin necrosis.

5. The following are not covered benefits:
 - a. Revision procedures unless there are surgical complications listed above.
 - b. Revisions for aesthetic/cosmetic reasons.
 - c. In breast cancer patients, surgery for asymmetry if the member is no longer receiving services related to the breast cancer.
 - d. Augmentation mammoplasty for asymmetry that is not cancer related. See C. Breast Reconstruction and Revision below.

6. Prior Authorization Requirements for EPO, PPO, SF-POS and Medicaid members only — **both** of the following must have prior authorization by Priority Health:
 - a. All unilateral reductions that are not related to current breast cancer care.
 - b. All bilateral reductions that do not meet criteria in 2.

Special Note: This policy is intended to comply with the requirements of the Women’s Health and Cancer Act of 1998.

7. Limitations and Exclusions:
 - a. Mastopexy procedures (e.g. breast ptosis) are not a covered benefit. These procedures are considered to be cosmetic in nature and not performed to relieve pain due to macromastia.
 - b. Reduction mammoplasty for cosmetic purposes (to improve appearance) is not a covered benefit.
 - c. Reduction mammoplasty to treat fibrocystic disease of the breasts is not a covered benefit.
 - d. Regardless of the Schnur Sliding Scale, breast reduction removing less than 350 grams from a breast is considered a cosmetic procedure and is not a covered benefit.
 - e. Chronic intertrigo, eczema, dermatitis, and/or ulceration in the inframammary fold, in and of itself, are not an indication for coverage.
 - f. Coverage is limited to one reduction mammoplasty per member lifetime with Priority Health

C. Breast Reconstruction and Revision

This section applies to reconstruction and revision for breast cancer. It would also apply to women at high risk of breast cancer who require prophylactic mastectomy.

Initial reconstruction can occur immediately after a mastectomy or be delayed until a patient undergoes radiation or chemotherapy or determines whether she wants breast reconstruction. Some women will opt for immediate breast reconstruction after mastectomy, while some may prefer delayed reconstruction. While some reconstructions can be completed in a single procedure, other techniques may require two or more surgical procedures for completion of the reconstructive process.

Further clarification of coverage for breast reconstruction and revision is outlined below.

1. Coverage for the breast affected by cancer, as well as for the breast(s) removed prophylactically (including bilateral prophylactic mastectomies). The following are covered benefits:
 - a. Treatment for complications of breast reconstruction including cellulitis, other infections, and lymphedema.
 - b. Revisions required by surgical complications including infection, hematoma or seroma, or skin or flap necrosis.
 - c. Capsulotomies/capsulectomies for pain or contractures (see II. A. Breast Implant Removal above) for coverage criteria.
 - d. Prosthesis removal for pain, contractures, rupture, leakage or infection. (see II.A. Breast Implant Removal above) for coverage criteria.
 - e. Scar revisions are only covered if one of the following apply:
 - i. The scar resulted from a serious complication such as infection or wound dehiscence from surgery or post-op period
 - ii. The scar revision is an integral (not incidental) part of another covered procedure
2. **The following are not covered benefits:**
 - a. Revisions for aesthetic/cosmetic reasons beyond the original reconstructive surgery unless there were surgical complications such as cellulitis, other infections, lymphedema, hematoma, or significant skin or flap necrosis. Examples of non-covered conditions would include nipple fading, loss of symmetry, for any reason, including tissue atrophy, after initial symmetry is achieved.
 - b. Breast reconstruction using the deep inferior epigastric perforator (DIEP) flap as it is not considered to be standard of care.
3. Additional coverage for the breast(s) removed prophylactically (including bilateral prophylactic mastectomies)*:



- a. An initial procedure (reduction, augmentation or mastopexy) on the contralateral breast to produce symmetry between the affected and unaffected breasts.
- b. A reduction on the unaffected breast is not subject to the 50% copay that applies to reduction mammoplasty unrelated to breast cancer.

* For specific criteria regarding prophylactic mastectomy for cancer risk reduction see policy # 91508 Prophylactic Cancer Surgery

4. Breast reconstruction surgery is also a covered benefit when incidental to disease and/or injury if
 - a. a functional impairment is established and surgery is intended to correct the functional impairment OR
 - b. Breast reconstructive surgery is performed to correct asymmetry of a breast when surgery has been performed on the other breast incidental to disease or injury; or
 - c. Coverage is **not** provided for breast reconstruction surgery that is not related to disease or trauma. Excluded conditions include, but are not limited to:
 - i. Absence or underdevelopment of chest muscles
 - ii. Abnormalities of the chest wall (such as pectus excavatum)
 - iii. Congenital underdevelopment or absence of the nipple or breast.

D. Male Gynecomastia

Simple mastectomy or reduction mammoplasty for bilateral male gynecomastia is most frequently done for cosmetic reasons and is not a covered benefit. It may be a covered benefit if the limits and indications below are met. Surgical excision of unilateral gynecomastia is only covered when clinical, mammographic, and fine needle aspirate data warrant excision as described below. Removal of fatty tissue only, by any method including suction-assisted lipectomy, is not covered.

1. Coverage Criteria for Adolescents-**all** of the following must be present:
 - a. Unilateral or bilateral grade III or grade IV symptomatic gynecomastia
 - a. glandular tissue >4 cm in diameter
 - b. persists after 12 months of unsuccessful medical treatment
 - c. patient has pain unresponsive to OTC medications and activities of daily living are significantly compromised
2. Coverage Criteria for Bilateral Gynecomastia in Adults-**all** of the following must be present:
 - a. Bilateral grade IV symptomatic gynecomastia
 - b. Gynecomastia has persisted for more than 3 years
 - c. Other pathological causes have been ruled out



- d. Gynecomastia persists after 12 months of unsuccessful medical treatment for symptomatic gynecomastia
 - e. Patient has pain unresponsive to OTC medications and activities of daily living are significantly compromised
3. Coverage for Unilateral Gynecomastia in Adults Priority Health will cover excisional biopsies for adult males with unilateral gynecomastia when malignancy is suspected.
 4. Prior Authorization Requirements for Medicaid members (all of the following are required). The following documentation should be provided by the requesting physician:
 - a. Patient's age
 - b. Physical description of the enlarged breast including symmetry, mass, induration and size
 - c. Medical history assessing the differential diagnosis including chronic diseases and medications
 - d. Previous work-up including mammogram and fine needle aspirate, where appropriate for evaluation of unilateral gynecomastia or masses.
 - e. High-quality original photographs for evaluation of the gynecomastia grade.

E. Mastectomy for Intractable Breast Pain

The efficacy and clinical application of mastectomy (simple or total) for intractable breast pain has not been proven to be a medically appropriate treatment and is not a covered benefit.

F. Screening Mammography and Breast MRI

1. Screening Mammography

Screening mammograms, conventional or digital, are a covered benefit when ordered by the primary care physician or affiliated specialist and performed by a participating provider and facility.

Coverage for screening mammography for an average risk woman is provided according to Michigan law. The State of Michigan requires coverage for one mammogram in a five-year period for women at least 35 years of age and less than 40 years of age. For women 40 years of age and older the State requires coverage for one mammogram per year.

Ultrasound and electrical impedance scans are not a covered benefit as screening tests for breast cancer. Conventional or digital mammography is considered to be the standard diagnostic method for breast cancer screening. MRI for breast cancer screening is only covered as specified below.

**2. Breast MRI**

American Imaging Management (AIM) provides prior authorization medical necessity review services on behalf of Priority Health for participating providers. Prior authorization for out-of-network providers must be requested through Priority Health. Please refer to AIM's Clinical Guideline (MRI of the Breast) for criteria (www.americanimaging.net).

III. MEDICAL NECESSITY REVIEW**A. Breast Implant Removal**

Required Not Required Not Applicable

B. Reduction Mammoplasty

Required for EPO, PPO, SF-POS and Medicaid members

C. Breast Reconstruction and Revision

Required Not Required Not Applicable

D. Male Gynecomastia

Required for PPO, EPO, Self-funded POS, and Medicaid members only

E. Mastectomy for Intractable Breast Pain

Required Not Required Not Applicable

F. Screening Mammography and Breast MRI

Required for Breast MRI only Not Required Not Applicable

IV. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO:** *This policy applies to all fully insured Priority Health HMO plans.*
- ❖ **POS:** *This policy applies to all fully insured Priority Health POS plans.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **PPO:** *This policy applies to all fully insured Priority Health Insurance Company PPO plans.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS).*
- ❖ **MEDICAID:** *Coverage is determined by the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87515--,00.html*
- ❖ **MiCHILD:** *For MiCHILD members, this policy will apply unless MiChild policies extend coverage beyond this coverage policy.*



V. BACKGROUND

A. Breast Implant Removal

In the US, an estimated 1-2 million patients, or approximately 1% of the adult female population, have breast implants. The incidence of implant rupture increases over time. One study revealed that the median lifespan of a silicone gel breast implant is 16.4 years. In that study, 79.1% of implants were intact at 10 years; the percentage decreased to 48.7% at 15 years.

According to the American Society of Plastic Surgeons, breast augmentation is the third most commonly performed cosmetic procedure in the United States. In 2005, 291,000 breast augmentation procedures were performed. More than 50,000 implant removal procedures were also reported in 2004.

A breast implant is a silicone shell filled with either silicone gel or saline. Some silicone gel may diffuse or “bleed” through the shell of an intact implant into the scar tissue or capsule that surrounds the implant. Rupture of an implant may be related to the length of time it has been in the body. All breast implants, like other medical devices, fail over time and need to be removed or replaced. Rupture may also be related to force or trauma.

Significant local complications of breast implants may require removal of the implant. Contracture is the most common local complication of breast implants.

Capsules of tightly-woven collagen fibers form as an immune response around a foreign body (e.g. breast implants, pacemakers, orthopedic joint prosthetics), tending to wall it off. Capsular contracture occurs when the capsule tightens and squeezes the implant. This contracture is a complication that can be very painful and distort the appearance of the implanted breast. The exact cause of contracture is not known. However, some factors include bacterial contamination, silicone rupture or leakage, and hematoma.

When saline breast implants break, they often deflate quickly and can be easily removed. Prospective studies of saline-filled breast implants approved by FDA in May 2000 showed rupture/deflation rates of 3-5% at 3 years and 7-10% at 5 years for augmentation patients.

When silicone implants break they rarely deflate, and the silicone from the implant can leak. The differential diagnosis of silicone breast implant rupture includes intracapsular and extracapsular ruptures. If the extruded silicone is contained by this fibrous capsule the rupture is termed intracapsular. If the silicone gel is extruded beyond the capsule, the rupture is termed extracapsular. If intracapsular ruptures are early or focal, extensive gel bleeding has an appearance similar to that of extracapsular rupture by MRI. Extracapsular rupture involves free silicone in the breast parenchyma, which can simulate other breast masses, including breast cancer, at mammography and sonography. An intracapsular rupture can progress to outside of



the capsule (extracapsular rupture), and when recognized, both conditions are generally agreed to indicate the need for removal of the implant. Clinically, extracapsular ruptures are often associated with a change in size and consistency of the breast. Extracapsular silicone has the potential to migrate, but most clinical complications have appeared to be limited to the breast and axillae in the form of granulomas (inflammatory nodules) and axillary lymphadenopathy.

B. Reduction Mammoplasty

Macromastia is the development of abnormally large breasts. Macromastia that may require treatment is distinguished from large, normal breasts by the presence of persistent, painful symptoms and physical signs. These commonly include chronic mechanical upper back and/or neck and/or shoulder pain as the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk.

Excessive breast weight may be reduced through a weight reduction management program or through surgical means. Reduction mammoplasty is the surgical excision of a substantial portion of the breast including the skin and the underlying glandular tissue, until a clinically normal size is obtained.

Surgery solely performed to reshape the breasts, in order to improve appearance and self-esteem, is considered to be cosmetic surgery. Reconstructive breast surgery post-mastectomy for breast cancer is a covered benefit and addressed in II. C. above. Treatment for gynecomastia, the excessive growth of the male mammary glands, is addressed in II. D. above.

C. Breast Reconstruction and Revision

Breast reconstruction surgery includes those surgical procedures which are intended to restore the normal appearance of the breast. This restoration occurs after surgery, accidental injury, or trauma.

Mastectomy for cancer is the most common reason women seek breast reconstruction, but other conditions such as severe post radiation changes or congenital deformities are other reasons that a woman may seek breast reconstruction.

Techniques of reconstruction include: tissue expansion, flap reconstruction, nipple areola reconstruction with subsequent implantation of a breast prosthesis. The tissue expander is a balloon-like device which is surgically placed under the chest tissue to create a breast-shaped space for the breast implant. Flap reconstruction allows for reconstruction using the patient's own tissues. Donor flap sites include the back, lower abdomen, buttocks, or lateral hip region. For a latissimus flap the latissimus dorsi muscle is used. This muscle is frequently used for reconstruction surgery due to its large size and versatility. For a TRAM flap (transverse rectus abdominus musculocutaneous flap) excess abdominal tissue is tunneled under the skin from the lower abdomen to the chest and used to replace the breast tissue. For a free flap, tissue from other body sites (such as buttock or lateral thigh region) is transferred to the chest.



Although breast reconstruction is a cosmetic procedure, there are both Federal and Michigan state laws requiring health plans to cover breast reconstruction in certain defined circumstances. The federal and state requirements differ.

D. Male Gynecomastia

Gynecomastia is defined as the presence of an abnormal proliferation of breast tissue in males. It is a common breast lesion accounting for more than 65 percent of male breast disorders. Gynecomastia has a broad range of causes that are classified as either physiological or pathological, although in many cases no specific cause can be found (idiopathic). In true gynecomastia, the breast enlargement is due to glandular breast tissue; in pseudogynecomastia, the breast enlargement is secondary to fat accumulation; and both glandular and fat tissue are present in mixed gynecomastia.

Physiologic gynecomastia occurs most frequently during times of male hormonal changes, resulting from the effect of an altered estrogen/androgen balance on breast tissue or from the increased sensitivity of breast tissue to a normal estrogen level.

Pubertal gynecomastia is a common condition with an overall incidence of 38 percent in males 10 to 16 years of age, increasing to 65 percent at age 14, and dropping to 14 percent in 16-year-old boys. During adolescence, 75 percent of the gynecomastia cases are bilateral but the breasts are often affected to different degrees. Pubertal gynecomastia often regresses spontaneously in six months, 75 percent within two years of onset, and 90 percent resolve within three years of onset.

In adults, gynecomastia is associated with increasing age due to progressive testicular hypofunction, an increase in body fat, and an increase in the estrogen/androgen ratio.

Pathological gynecomastia is associated with both androgen deficiency and estrogen excess. Both causes may be due to medications, diseases related to endocrinologic abnormalities, tumors, chronic disease, chromosomal abnormalities, familial disorders, and other miscellaneous conditions. While there is always a concern when a mass is present, breast cancer accounts for only 0.2 percent of all malignancies in male patients. A suspicious mass or lesion requires biopsy.

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales:



- Grade I** Small breast enlargement with localized button of tissue that is concentrated around the areola.
- Grade II** Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
- Grade III** Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present.
- Grade IV** Marked breast enlargement with skin redundancy and feminization of the breast.

<i>Causes of Gynecomastia</i>	
Physiologic	Tumor
Neonatal	Pituitary
Pubertal	Adrenal
Age	Testicular
Pathologic	Breast
Drugs, including marijuana	Chronic Disease
Endocrinopathy	Liver disease, cirrhosis
Primary hypogonadism	Renal failure
Secondary hypogonadism	Malnutrition
Hyperthyroidism	Pulmonary
Adrenal disorders	Nervous system damage
Familial	
Idiopathic	

E. Screening Mammography and Breast MRI

Screening Mammography

Screening mammography involves radiographic (X-ray) examination of the breast performed at regular intervals, usually every 1 to 2 years, to detect breast cancer before it displays signs or symptoms. The goals of screening mammography for average risk women without any symptoms are to reduce breast cancer morbidity and mortality (illness and death). This can be accomplished by the accurate detection of the disease before it has metastasized (spread from the breast to another part of the body), when treatment can be less aggressive, and when the likelihood of long-term remission (decrease in symptoms) or cure is the highest.

According to the State of Michigan Insurance Code, breast cancer screening is defined as mammography using a standard 2-view per breast, low-dose radiographic examination of the breasts, and using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

The Insurance Code goes on to define breast cancer diagnostic services as procedures intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammogram, mammography, surgical breast biopsy, and pathologic examination and interpretation.

Breast MRI

Women with inherited mutations of the *BRCA1* or *BRCA2* gene have the highest risk of breast cancer. They make up 5 to 10 percent of women with breast cancer and are



also at increased risk for ovarian cancer. The cumulative risk of breast cancer in women with *BRCA1* mutations is 3.2 percent by the age of 30 years, 19.1 percent by the age of 40, 50.8 percent by the age of 50, 54.2 percent by the age of 60, and 85.0 percent by the age of 70; the cumulative lifetime risk for carriers of *BRCA1* or *BRCA2* mutations is 50 to 85 percent.

Screening mammography detects less than half of the breast cancers in mutation carriers, perhaps owing to young age, dense breasts, or pathological features of the tumor. Cancers in mutation carriers grow rapidly; half of them appear in the interval between annual mammograms. The median size of such "interval cancers" is 1.7 cm, and half have spread to axillary lymph nodes by the time they are detected. It has been suggested that supplementing mammography with other imaging techniques, shorter screening intervals, or both may be valuable in mutation carriers. Liberman, L. "Breast Cancer Screening with MRI—What are the Data for Patients at High Risk?" *New England Journal of Medicine*, 351; 5, July 29, 2004, pp. 497-500.

A recent study suggests that MRI may be a viable option for breast cancer screening among carefully selected women at high risk for the disease due to familial or genetic predisposition. Although concerns regarding an increase in invasive follow-up procedures due to the reduced specificity of MRI screening may be warranted, the anxiety level regarding breast cancer among women with familial or genetic predisposition for the disease is already heightened; therefore, it is difficult to determine the clinical implication of additional follow-up procedures. Furthermore, women in this high-risk category are at greater risk for aggressive forms of the disease at an earlier age; consequently, mammograms are often indicated at a young age when they are less effective due to the dense breast tissue of younger women. MRI may be of value for this patient population; however, further studies are necessary to better define the appropriate patient population, as well as to determine if clinical and survival benefits outweigh the high cost of the procedure. *Kriege M, Brekelmans CT, Boetes C, et al. Efficacy of MRI and mammography for breast-cancer screening in women with a familial or genetic predisposition. N Engl J Med. 2004;351(5):427-437.*

VI. CODING INFORMATION

A. Breast Implant Removal

ICD-9 Codes that may support medical necessity

996.54	Mechanical complication due to breast prosthesis
996.69	Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft
996.79	Other complications due to other internal prosthetic device, implant, and graft

CPT/HCPCS Codes

19328	Removal of intact mammary implant
19330	Removal of mammary implant material

B. Reduction Mammoplasty



ICD9 codes not specified – see criteria

CPT/HCPCS code

19318 Reduction Mammoplasty

C. Breast Reconstruction and Revision

ICD-9 Codes that support medical necessity

174.0	Malignant neoplasm of female breast....Nipple and areola
174.1	Malignant neoplasm of female breast....Central portion
174.2	Malignant neoplasm of female breast....Upper-inner quadrant
174.3	Malignant neoplasm of female breast....Lower-inner quadrant
174.4	Malignant neoplasm of female breast....Upper-outer quadrant
174.5	Malignant neoplasm of female breast....Lower-outer quadrant
174.6	Malignant neoplasm of female breast....Axillary tail
174.8	Malignant neoplasm of female breast....Other specified sites of female breast
174.9	Malignant neoplasm of female breast....Breast (female), unspecified
198.81	Secondary malignant neoplasm of other specified sites....Breast
233.0	Carcinoma in situ of breast and genitourinary system....Breast
233.3	Carcinoma in situ of breast and genitourinary system....Other and unspecified female genital organs
238.3	Neoplasm of uncertain behavior of other and unspecified sites and tissues , breast
239.3	Neoplasms of unspecified nature....Breast
V10.3	Personal history of malignant neoplasm....Breast
V50.41	Prophylactic organ removalBreast

CPT/HCPCS Codes:

*The above diagnoses support medical necessity for the following procedures.
All other indications must be prior authorized*

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 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm (List separately in addition to code for primary procedure)
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
19316	Mastopexy
19318	Reduction Mammoplasty (<i>see Section B for other indications</i>)
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

- 19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
- 19350 Nipple/areola reconstruction
- 19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
- 19361 Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant
- 19364 Breast reconstruction with free flap
- 19366 Breast reconstruction with other technique
- 19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
- 19368 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
- 19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
- 19370 Open periprosthetic capsulotomy, breast
- 19371 Periprosthetic capsulectomy, breast
- 19380 Revision of reconstructed breast
- 19396 Preparation of moulage for custom breast implant (*not covered for Medicaid*)
- C1789 Prosthesis, breast (implantable)
Bill with Revenue Code 0272 Sterile supply
(*No separately payable for Medicaid*)
- L8039 Breast prosthesis, not otherwise specified
(*not separately payable for Medicaid*)
Billed with Revenue Code 0274 Prosthetic/orthotic devices
- L8600 Implantable breast prosthesis, silicone or equal
(*not separately payable for Medicaid*)
Billed with Revenue Code 0278 Other implants

Not Covered:

- S2066 Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
- S2067 Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral
- S2068 Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral

D. Male Gynecomastia

ICD-9 Codes that may support medical necessity



*The following diagnosis codes support medical necessity for the procedures code indicated by **

- 611.1 Hypertrophy of Breast, gynecomastia
611.72 Lump or mass in breast

CPT/HCPCS Codes:

- 15877 Suction assisted lipectomy, trunk
(*Not covered for Medicaid*)
19300 Mastectomy for gynecomastia
19303 Mastectomy, simple, complete
19304 Mastectomy, subcutaneous
19318 Reduction Mammoplasty

Special Note: Most benefit plans have a 50% co-pay on professional fees effective 1/1/2003. A rider allowing coverage at a higher level is available to employers.

E. Mastectomy for Intractable Breast Pain (*Not covered*)**ICD-9 Codes:**

- 611.71 Mastodynia

CPT/HCPCS Codes:

- 19301 Mastectomy, partial; (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302 Mastectomy, partial; with axillary lymphadenectomy (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303 Mastectomy, simple, complete
19304 Mastectomy, subcutaneous
19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

F. Screening Mammography and Breast MRI

ICD-9 Codes that may support medical necessity:

Not specified

CPT/HCPCS Codes

- 77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
0159T Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for

interpretation, breast MRI (List separately in addition to code for primary procedure)

- 77055 Mammography; unilateral
- 77056 Mammography; bilateral
- 77057 Screening mammography, bilateral (2-view film study of each breast)
- 77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)
- 77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)
- G0202 Screening mammography, producing direct digital image, bilateral, all views
- G0204 Diagnostic mammography, producing direct digital image, bilateral, all views
- G0206 Diagnostic mammography, producing direct digital image, unilateral, all views

Not Covered:

- 0060T Electrical impedance scan of the breast, bilateral (risk assessment device for breast cancer)
- 0061T Destruction/reduction of malignant breast tumor including breast carcinoma cells in the margins, microwave phased array thermotherapy, disposable catheter with combined temperature monitoring probe and microwave sensor, externally applied microwave energy, including interstitial placement of sensor

VII. REFERENCES

A. Breast Implant Removal

1. “Breast Implant Removal”, Aetna Policy Bulletin @ <http://www.aetna.com/cpb/data/CPBA0142.html> (Retrieved December 4, 2006)
2. “Reconstructive Breast Surgery and Management of Breast Implants” The Regence Group @ <http://www.regence.com/trgmedpol/surgery/sur40.html> (Retrieved December 4, 2006)
3. “Breast Implant Removal”, Cigna Policy @ http://www.cigna.com/health/provider/medical/procedural/coverage_positions/medical/index.html#B (Retrieved December 4, 2006) “Cosmetic and Reconstructive Surgery” WPS LCD.
4. American Society of Plastic Surgeons, Silicone breast Implant Surgery, retrieved on July 31, 2006 from:



http://www.plasticsurgery.org/public_education/Silicone-Breast-Implant-Surgery.cfm.

5. Centers for Medicare and Medicaid, Complete Guide to Medicare Coverage Issues, Medicare National Coverage Determinations (NCD140.2, 140.4) [Pub. 100-03], Ingenix, Inc., May 2006.
6. Nagelin-Anderson, E., and D. Zuckerman, Complications of Saline Breast implants: What You Should Know Before You Decide on Augmentation, Issue Brief, National Research Center for Women & Families, Retrieved on July 31, 2006 from:
<http://www.center4research.org/ibrief-aug042003.html>
7. Pittet, B., Montandon, D., and D. Pittet, Infection in breast implants, Lancet Infectious Disease, Vol. 5, 94-106, February 2005.
8. United States Food and Drug Administration (FDA), Breast Implant Consumer Handbook, Retrieved on July 31, 2006 from:
www.fda.gov/cdrh/breastimplants/
9. Wikipedia, Breast Implant, Retrieved on July 31, 2006 from:
http://en.wikipedia.org/wiki/Breast_implant
10. Wisconsin Physicians Service (WPS), Local Coverage Decision(LCD), Cosmetic and Reconstructive Surgery, GSURG-032, Original determination date: 09/16/2004, Revision date: 02/16/2005. Retrieved on 7/27/2006 from:
<http://www.wpsic.com/medicare/policies/wisconsin/gsurg032.pdf>

B. Reduction Mammoplasty

1. Care Choices HMO Subscriber Certificate, September 9, 2003.
2. Schnur, Paul, MD, "Reduction Mammoplasty – The Schnur Sliding Scale Revisited" Guest Editorial, Annals of Plastic Surgery, 42(1); 107-108, 1999.
3. Wisconsin Physicians Service (WPS), "Cosmetic Surgery and Reconstructive Surgery," WPS Local Medical Review Policy, contractor policy number GSURG-032 most recent Michigan revision 2/16/05 retrieved on May 16, 2005
<http://www.wpsic.com/medicare/policies/wisconsin/gsrg32.shtml>.
4. Macromastia Definition. Retrieved on May 17, 2005 from
http://www.mamc.amedd.army.mil/referral/guidelines/plsurg_macro_mastia.htm.

C. Breast Reconstruction and Revision

1. U.S. Department of Labor. Women's Health and Cancer Rights Act of 1998 at www.dol.gov/ebsa/Publications/whcra.html
2. MCLA 500. 3406(a).

D. Male Gynecomastia

1. Colombo-Benkmann M; Buse, B; Stern J; Herfarth C. Indications for and Results of Surgical Therapy for Male Gynecomastia, American Journal of Surgery. 1999 Jul;178(1):60-3.



2. Volpe CM; Raffetto JD; Collure DW; Hoover EL; Doerr RJ. Unilateral Male Breast Masses: Cancer Risk and Their Evaluation, The American Surgeon. 1999 Mar;65(3):250-3.
3. Neuman, JF. Evaluation and Treatment of Gynecomastia, American Family Physician. 1997 Apr;55(5):1835-1844.
4. McGrath, M.H., Mukerji, S. Plastic surgery and the teenage patient. J Pediatr Adolesc Gynecol. 13:105-118, 2000.
5. Sher, E.S., Migeon, C.J., Berkovitz, G.D. Evaluation of boys with marked breast development at puberty. Clin Pediatr. 37:367-71, 1998.
6. Simon, B.E., Hoffman, S., Kahn, S. Classification and surgical correction of gynecomastia. Plast. Reconstr. Surg. 51:48-52, 1973.
7. American Society of Plastic Surgeons (ASPS). (1995). Position paper: Gynecomastia. Retrieved on January 19, 2004 from: <http://www.plasticsurgery.org/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=9393>.
8. Emedicine (2005). Gynecomastia. Retrieved on September 29, 2005 from <http://www.emedicine.com/med/topic934.htm>.

E. Screening Mammography and Breast MRI

1. HAYES Alert. Screening Mammography and Improved Adjuvant Therapies Led to Decline in U.S. Breast Cancer Mortality Rates (VIII:11). Lansdale, PA: HAYES, Inc.; November 2005.
2. HAYES Alert. Digital Superior to Film Mammography in Subsets of Asymptomatic Women (VIII:9). Lansdale, PA: HAYES, Inc.; September 2005
3. HAYES Alert. Study Doubts Benefits of Breast Cancer Screening in Routine Clinical Practice (VIII:8). Lansdale, PA: HAYES, Inc.; August 2005.
4. HAYES Medical Technology Directory. Update Search. Screening Mammography for Women at Average Risk for Breast Cancer. Lansdale, PA: HAYES, Inc.; April 2005.
5. Hayes Medical Technology Directory. Magnetic Resonance Imaging for Breast Cancer Screening in Women at High Risk. Lansdale, PA: HAYES, Inc.; January 2005.
6. HAYES Alert. New Cancer Screening Guidelines Discard Breast Self-Exam. Lansdale, PA: HAYES, Inc.; June 2003.
7. HAYES Medical Technology Directory. Screening Mammography for Women at Average Risk for Breast Cancer. Lansdale, PA: HAYES, Inc.; February 2002.
8. State of Michigan. Insurance Code Section 500.3616(2).



9. American Cancer Society-News Release (Response to Kriege et. al. 7/29/04): Available on the World Wide Web @ http://www.cancer.org/docroot/NWS/content/NWS_1_1x_MRI_Finds_Breast_Cancer_in_High-Risk_Women.asp (Retrieved August 18, 2004)
10. HAYES, Alert. Clinical Studies MRI vs. Mammography for Breast Cancer Screening in Women at High Risk Volume VII, Number 8 - August 2004
11. Kriege M, Brekelmans CT, Boetes C, et al. Efficacy of MRI and mammography for breast-cancer screening in women with a familial or genetic predisposition. N Engl J Med. 2004;351(5):427-437.
12. Liberman, L. "Breast Cancer Screening with MRI—What are the Data for Patients at High Risk?" New England Journal of Medicine, 351; 5, July 29, 2004, pp. 497-500
13. Magnetic Resonance Imaging of the Breast in Screening Women Considered to Be at High Genetic Risk of Breast Cancer Technology Evaluation Center, Blue Cross Blue Shield Association, Volume 18, No. 15, December 2003
14. National Breast Cancer Coalition (Response to Kriege, et.al.): Available on the World Wide Web @ <http://www.natlbcc.org/bin/index.asp?strid=676&depid=20> (Retrieved August 18, 2004)
15. American Cancer Society Guidelines for Breast Screening with MRI as an Adjunct to Mammography CA Cancer J Clin 2007;57:75–89

AMA CPT Copyright Statement:

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.