



**BREAST RELATED PROCEDURES\***

Effective Date: August 18, 2010

Review Dates: 8/07, 8/08, 8/09, 4/10, 6/10,  
8/10

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:

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Deletions:

- Pg 5, Section II, B, 3, a, language indicating “evaluation by a physiatrist” has been deleted and replaced with “evaluation by a physician”.
- Pg 5, Section II, B, 3, b, 2, iii, criteria indicating one of the following therapeutic measures must be completed: chiropractic care/physical therapy/exercises/posturing maneuvers/osteopathic manipulation has been removed.

Additions:

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**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.

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## 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:

	<b>Severe</b>	<b>Moderate/Mild</b>
• 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

**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](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**

<b>Body Surface Area (m<sup>2</sup>)</b>	<b><u>Average grams of tissue per breast to be removed</u></b>
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:  $(BSA \text{ (in m}^2\text{)}) = [\text{height (cm)}]^{0.718} \times [\text{weight (kg)}]^{0.427} \times .007449$ . 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. Symptom score should be greater than or equal to 3.
  - 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. Physician 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 physician 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:

	<b>Severe</b>	<b>Moderate/Mild</b>
• 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 **both** of the following:
    - i. Supportive devices (e.g., proper bra support/fitting, wide bra straps)
    - ii. Analgesic/NSAIDs
  3. The patient has a symptom score greater than or equal to 3 based on the following:

	<b>Severe</b>	<b>Moderate/Mild</b>
• 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. 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*

3. 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.
4. 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.

5. **The following are not covered benefits:**

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.

**D. Microsurgical Lymph Node Transplantation for Postmastectomy**

**Lymphedema** is considered experimental and investigational review for exceptions may be made in the following circumstances:

1. Chronic recurrent infection, or
2. Clinical functional impairment as defined as a condition which interferes with activities of daily living, and there is reasonable evidence to support that this intervention will correct the condition to which it is being attributed to. Further definition can be located in the Certificate of Coverage.

**E. 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.

**F. 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.

**G. 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](http://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. Microsurgical Lymph Node Transplantation for Postmastectomy Lymphedema**

Required  Not Required  Not Applicable

#### **E. Male Gynecomastia**

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

#### **F. Mastectomy for Intractable Breast Pain**

Required  Not Required  Not Applicable

#### **G. 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/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO 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.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS).*
- ❖ **MEDICAID:** *If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule, the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-159815--00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--00.html) will govern.*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

#### 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

#### **ICD-9 codes that may support medical necessity**

- 611.1 Hypertrophy of Breast
- 719.41 Pain in joint, shoulder region
- 723.1 Cervicalgia
- 724.5 Backache, unspecified
- 782.0 Disturbance of skin sensation

#### **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
611.83	Capsular contracture of breast implant
612.0	Deformity of reconstructed breast
612.1	Disporportion of reconstructed breast
V10.3	Personal history of malignant neoplasm...Breast
V43.82	Breast replaced by other means
V50.41	Prophylactic organ removal ...Breast
V51.0	Encounter for breast reconstruction following mastectomy

**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 Priority Health Medicaid)*
- C1789 Prosthesis, breast (implantable)  
 Bill with Revenue Code 0272 Sterile supply  
*(not separately payable for Priority Health Medicaid)*
- L8039 Breast prosthesis, not otherwise specified  
*(not separately payable for Priority Health Medicaid)*  
 Billed with Revenue Code 0274 Prosthetic/orthotic devices
- L8600 Implantable breast prosthesis, silicone or equal  
*(not separately payable for Priority Health Medicaid)*  
 Billed with Revenue Code 0278 Other implants
- 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. Microsurgical Lymph Node Transplantation for Postmastectomy Lymphedema

**ICD-9 Codes that may support medical necessity**

457.0 Postmastectomy lymphedema syndrome

**CPT/HCPCS Codes:**

19499 Unlisted procedure, breast *(Explanatory notes must accompany claim)*

E. Male Gynecomastia

**ICD-9 Codes that may support medical necessity**

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.

F. 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

G. Screening Mammography and Breast MRI

**ICD-9 Codes that support medical necessity for screening mammography only:**

V76.10 Breast screening, unspecified

V76.11 Screening mammogram for high-risk patient

V76.12 Other screening mammogram

V76.19 Other screening breast examination

V16.3 Family history of malignant neoplasm of breast

V10.3 Personal history of breast cancer

**CPT/HCPCS Codes**

77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral (*prior authorization required*)

77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral (*prior authorization required*)

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

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