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## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Mastectomy/Breast Conserving Surgery**

Mastectomy is the surgical removal of all of the breast tissue. Breast conserving surgery is removal of part of the breast and can be called lumpectomy, tylectomy, quadrantectomy, or segmentectomy. Mastectomy or breast conserving surgery is generally done for breast cancer.

### **1.2 Male Gynecomastia**

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

### **1.3 Prophylactic Mastectomy**

Prophylactic mastectomy is the removal of the breast(s) to prevent development of cancer in recipients considered to be at high risk of developing or redeveloping breast cancer. Fibrocystic disease is not a legitimate reason for mastectomy in the absence of documented risk factors.

### **1.4 Reduction Mammoplasty**

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

### **1.5 Breast Reconstructive Surgery**

Breast reconstructive surgery is performed following a mastectomy to establish symmetry with the contralateral breast or following bilateral mastectomy. It includes the surgical creation of a new breast mound and the nipple/areolar reconstruction, which is accomplished with small local flaps for the nipple and either tattooing or a skin graft for the areola. Reconstructive breast surgery may also include reduction mammoplasty, mastopexy, or augmentation on the contralateral breast to establish symmetry. Breast implants, tissue flaps, or both are surgically placed in the area where natural breast tissue has been removed.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

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

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

**42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or

procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

*Basic Medicaid Billing Guide:* <http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

### 3.0 When the Procedure, Product, or Service Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

### 3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### 3.2 Specific Criteria

#### 3.2.1 Mastectomy

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

- a. Malignant neoplasm of the breast
- b. Secondary malignant neoplasm of the breast
- c. Carcinoma in situ of the breast

#### 3.2.2 Mastectomy for Male Gynecomastia

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

- a. An adult recipient has a history of gynecomastia that persists for more than 3 to 4 months after pathological causes are ruled out.
- b. An adolescent's gynecomastia persists more than 6 months after pathological causes are ruled out.
- c. The excessive tissue is glandular and not fatty tissue as confirmed by clinical exam and either ultrasound or mammogram.
- d. Other causes of gynecomastia such as obesity, adolescence, and drug treatments (gynecomastia resolves with the discontinuation of the medication) have been ruled out.
- e. The excessive breast tissue development is not caused by non-covered therapies, alcohol, or use of illicit drugs such as marijuana or anabolic steroids, etc. (gynecomastia resolves with the discontinuation of the illicit drug usage).
- f. The recipient's body mass index (BMI) is less than or equal to 30 (<http://www.halls.md/ideal-weight/body.htm>)
- g. The recipient has a documented history of significant medical symptoms due to the gynecomastia that are not resolved by conservative treatments.

### 3.2.3 Prophylactic Mastectomy

**Prophylactic mastectomy is covered when any of the following criteria are met:**

- a. Breast biopsy indicates that the recipient is at high risk for breast cancer, that is, has atypical hyperplasia or lobular carcinoma-in-situ (LCIS), which may also be an indication for bilateral mastectomy OR
- b. Personal history of breast cancer (invasive ductal, invasive lobular, or ductal carcinoma-in-situ) in the contralateral breast and/or personal positive BRCA1 or BRCA2 genetic testing **OR**
- c. Personal history of contralateral breast cancer in a pre-menopausal woman

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

- a. Family history strongly suggestive of an autosomal dominant pattern of inheritance of a genetic mutation predisposing to breast cancer and/or ovarian cancer
- b. Immediate family history of breast cancer (mother, sister, daughter, brother, father)
- c. Personal history of ovarian cancer or history of a first-degree relative with ovarian cancer
- d. Severe benign disease (such as fibrocystic disease or post-traumatic fat necrosis) that interferes with the ability to read mammograms as documented by a radiologist

### 3.2.4 Reduction Mammoplasty

Reduction mammoplasty is only covered when performed as a part of a reconstructive surgery that meets the requirements as outlined in **Subsection 3.2.5**.

### 3.2.5 Breast Reconstructive Surgery

- a. Breast reconstructive surgery of the affected breast and reduction, mastopexy, and/or augmentation of the contralateral breast are covered in association with the primary mastectomy procedure for the following conditions:
  1. Malignant neoplasm of the breast
  2. Secondary malignant neoplasm of the breast
  3. Carcinoma in situ of the breast, either lobular or ductal
  4. Congenital absence of the breast (Poland's syndrome)
  5. Prophylactic mastectomy when the criteria listed in **Subsection 3.2.3** are met
- b. Breast implants are covered when surgically placed in the area where the natural breast tissue has been removed for a medically necessary mastectomy or to achieve symmetry after medically necessary breast surgery.
- c. Periprosthetic capsulotomy or capsulotomy procedures are covered for contractions or adhesions following reconstruction surgery when the contractions or adhesions are caused by medically necessary chemotherapy/radiation treatments for breast cancer.

## 4.0 When the Procedure, Product, Service Is Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure unnecessarily duplicates another provider's procedure; or
- d. the procedure is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Criteria

The N.C. Medicaid program does not cover the following:

- a. Breast implants when used for breast enlargement for cosmetic purposes
- b. Removal of mammary implants or mammary implant material for cosmetic purposes
- c. Augmentation mammoplasty with or without prosthesis for cosmetic purposes
- d. Correction of inverted nipples
- e. Preparation of moulage for custom breast implants
- f. Periprosthetic capsulotomy and periprosthetic capsulectomy procedures following cosmetic augmentation.
- g. Breast reduction except when the criteria in **Subsection 3.2.5** are met.
- h. Mastopexy except when the criteria in **Subsection 3.2.5** are met.

## 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

## 5.1 Prior Approval

### 5.1.1 Mastectomy for Breast Cancer

Mastectomy for breast cancer does not require prior approval.

### 5.1.2 Mastectomy for Male Gynecomastia

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

- a. Height (in inches), weight (in pounds), and age
- b. Unclothed pre-operative photographs from the chin to the waist (or lowest extent of breasts, if lower), including standing frontal and side views with arms straight down at the sides
- c. Medical record documentation of objective signs and symptoms and their duration; prior medical management, including the recipient's current medications; endocrine study results; and confirmation that the excessive tissue is glandular
- d. A list of subjective symptoms caused by breast enlargement with supporting medical record documentation of significant medical symptoms
- e. Evidence of exclusion of other medical problems that may cause or contribute to the significant medical symptoms as documented in the medical record
- f. Medical record documentation by the requesting surgeon that the excessive breast tissue is not caused by non-covered therapies, alcohol, or usage of illicit drugs such as marijuana or anabolic steroids

### 5.1.3 Prophylactic Mastectomy

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

- a. History and physical
- b. Diagnoses
- c. Medical records to demonstrate the criteria from **Subsection 3.2.3**
- d. Plan of treatment, including any planned reconstruction

### 5.1.4 Reduction Mammoplasty

Unilateral reduction mammoplasty is covered in cases of congenital absence or loss of significant breast tissue of the contralateral breast subsequent to trauma or medically necessary (cancer or high cancer risk) mastectomy as described in **Subsection 3.2.5**.

## 5.2 Breast Reconstructive Surgery

### 5.2.1 Candidates for Surgery

The best candidates for breast reconstructive surgery are women whose cancer, as far as can be determined, seems to have been eliminated by mastectomy. It is understood that patients with known metastasis would not be candidates for reconstruction, according to the American Society of Plastic Surgeons ([http://www.plasticsurgery.org/patients\\_consumers/procedures/BreastReconstruction.cfm](http://www.plasticsurgery.org/patients_consumers/procedures/BreastReconstruction.cfm)).

### 5.2.2 Prior Approval

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

- a. History and physical
- b. Diagnoses
- c. Signs and symptoms
- d. Complete treatment plan, including any contralateral surgery
- e. A statement from the requesting surgeon of the presence or absence of metastasis and its extent if present

### 5.2.3 Policy Guidelines for Breast Reconstruction Surgery

The policy guidelines for breast reconstructive surgery are as follows:

- a. Breast reconstruction, including implant material, is limited to once per occurrence of breast cancer.
- b. Removal of a mammary implant or mammary implant material is covered when medically necessary. Implant replacement for cosmetic intention is not covered. Prior approval is required.
- c. Periprosthetic capsulotomy and periprosthetic capsulectomy procedures are covered when it is medically necessary to remove the fibrous scar tissue. These procedures require prior approval. For pain or situations such as visible distortion or malposition of an implant, the prior approval request and supporting documents must indicate medical necessity.
- d. If the reconstruction is to follow a prophylactic mastectomy, prior approval must be obtained.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

## 7.0 Additional Requirements

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

### 7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements

### 7.2 FDA Approval

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

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** January 1, 1999

### Revision Information:

Date	Section Updated	Change
10/01/04	Section 1.0	The definition was modified to include reduction mammoplasty of the non-diseased breast to achieve symmetry following a medically necessary mastectomy; prophylactic mastectomy; and mastectomy for male gynecomastia.
10/01/04	Section 3.0	Coverage criteria for prophylactic mastectomy and mastectomy for male gynecomastia was added.
10/01/04	Section 3.3.5	Personal positive BrCA1 and BrCA2 genetic testing added.
10/01/04	Sections 3.5, 5.5, 8.3.5	Added information about reconstruction after prophylactic mastectomy.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
7/1/08	Section 1.3	Clarified that fibrocystic disease alone is not a legitimate reason for mastectomy.
7/1/08	Section 1.5	Added detail to description of breast reconstruction.
7/1/08	Section 2.2	Added legal citation.
7/1/08	Section 3.1	Added section on general criteria for coverage.

Date	Section Updated	Change
7/1/08	Section 3.3	Separated requirements for adult and adolescent patients with male gynecomastia. In adults the condition must persist for more than 3 to 4 months after ruling out (and treating for, if applicable) pathological causes. In adolescents the condition must persist for more than 6 months after pathological causes are ruled out. Changed the weight requirements from “not more than 25% over the ideal weight for his height based on the Metropolitan Life Insurance tables” to “BMI less than or equal to 30.” Improved English wording.
7/1/08	Section 3.4	Added autosomal dominant inheritance as one of the acceptable criteria; required documentation by a radiologist that fibrocystic disease is severe enough to interfere with reading mammograms; updated BrCA1 and BrCA2 to BRCA1 and BRCA2; added close relatives with ovarian cancer.
7/1/08	Section 3.5	Grammatical updates; deleted reference to Metropolitan Life Insurance height and weight tables; specified that symptoms must not have improved with conservative medical management; required documentation for unresponsive intertrigo; deleted axillary inlet syndrome as a symptom acceptable for reduction; specified that the formula given in a.6(b) is the Mosteller formula; added requirements for how much breast tissue will be removed.
7/1/08	Section 3.6	Substituted “mastopexy and/or augmentation” for “mammoplasty.”
7/1/08	Section 4.1	Updated standard statement of noncoverage.
7/1/08	Section 4.2	Deleted “revision of reconstructed breast” from the list of non-covered items; in letter g, changed “for cosmetic purposes” to “following cosmetic augmentation.”
7/1/08	Section 5.2	Added “record” to “medical documentation”; letter c, added duration of signs of symptoms, endocrine study results, and confirmation that the excessive tissue is glandular; changed “debilitating” to “significant medical”; added requirement for documentation that the condition does not result from non-covered therapies or illicit drugs.
7/1/08	Section 5.3	Added requirement for plan of treatment to specify planned reconstruction.

<b>Date</b>	<b>Section Updated</b>	<b>Change</b>
7/1/08	Section 5.4	Added requirement for recent negative mammogram for women 40 years of age or older. Letter d, deleted requirement for measurement from suprasternal notch to each nipple; changed “certification” to “medical record documentation”; deleted lordosis and axillary inlet syndrome as objective signs of medical necessity; deleted chronology of symptoms from required documentation; deleted documentation requirement of intent to remove at least 500 g of breast tissue.
7/1/08	Section 5.5.1	Added URL for Web site of American Society of Plastic Surgeons.
7/1/08	Section 5.5.2	Specified that treatment plan must be complete, including any contralateral surgery; added requirement that surgeon specify absence and presence (with extent) of metastasis.
7/1/08	Section 5.5.3	Specified that coverage is limited to once per cancer occurrence and that cosmetic implant replacement is not covered.
7/1/08	Section 7.1	Set this section off from EPSDT language.
7/1/08	Section 7.2	Added standard statement about records retention.
7/1/08	Section 7.3	Added standard statement about federal and state requirements.
7/1/08	Section 8.0	Moved billing guidelines to Attachment A, Claims-Related Information.
7/1/08	Attachment A, A	Updated claim type to standard language.
7/1/08	Attachment A, B	Added fourth digit to 175 range; corrected code descriptions throughout.
7/1/08	Attachment A, C	Added column to show whether prior approval is required; deleted codes 19140, 19160, 19162, 19180, 19182, 19200, 19220, and 19240; added range 19301 through 19307; changed capsulectomy to capsulotomy for code 19370; added two additional codes, 11920 for nipple tattooing and 19380 for breast reconstruction revision.
12/1/10	Subsection 2.0	Updated Web site links
12/1/10	Subsection 3.1	Updated to standard policy language
12/1/10	Subsection 3.2.4	Deleted General Criteria for Reduction Mammoplasty
12/1/10	Subsection 4.2	Added h. mastopexy except when the criteria in Subsection 3.2.5 are met

<b>Date</b>	<b>Section Updated</b>	<b>Change</b>
12/1/10	Subsection 5.1.4	Deleted a., c., and d, and left Subsection wording to read: “Unilateral reduction mammoplasty is covered in cases of congenital absence or loss of significant breast tissue of the contralateral breast subsequent to trauma or medically necessary (cancer or high cancer risk) mastectomy as described in <b>Subsection 3.2.5.</b> ”
12/1/10	Subsection 6.0	Updated to standard policy language
12/1/10	Subsection 7.0	Updated to standard policy language
12/1/10	Attachment A	B. Deleted Reduction Mammoplasty - type of surgery, diagnosis code and description Added Reduction mammoplasty on a contralateral breast - type of surgery, diagnosis code and description
12/1/10	Attachment A	Added claim type, modifiers, billing units, place of service, co pays

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

### A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/8371)

### B. Diagnosis Codes That Support Medical Necessity

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

Type of Surgery	Diagnosis Code	Description
Mastectomy	174.0 through 174.9	Malignant neoplasm of female breast
	175.0 through 175.9	Malignant neoplasm of male breast
	198.81	Secondary malignant neoplasm of other specified sites; Breast
	233.0	Carcinoma in situ of breast and genitourinary system; Breast
	238.3	Neoplasm of uncertain behavior of other and unspecified sites and tissues; Breast
Mastectomy for male gynecomastia	611.1	Other disorders of breast; Hypertrophy of breast
Prophylactic mastectomy	V10.3	Personal history of malignant neoplasm; Breast
	V16.3	Family history of malignant neoplasm; Breast
Reduction mammoplasty on a contralateral breast	612.1	Disproportion of reconstructed breast
Breast reconstructive surgery	174.0 through 174.9	Malignant neoplasm of female breast
	198.81	Secondary malignant neoplasm of other specified sites; Breast
	233.0	Carcinoma in situ of breast and genitourinary system; Breast
	238.3	Neoplasm of uncertain behavior of other and unspecified sites and tissues; Breast
	V10.3	Personal history of malignant neoplasm; Breast
	V16.3	Family history of malignant neoplasm; Breast

**C. Procedure Codes**

Type of Surgery	PA Required	Procedure Code	Description
Mastectomy	no	19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
		19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
		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
Mastectomy for male gynecomastia—prior approval required	yes	19300	Mastectomy for gynecomastia
Prophylactic mastectomy—prior approval required	yes	19303	Mastectomy, simple, complete
	yes	19304	Mastectomy, subcutaneous
Breast reconstructive surgery—do not require prior approval, except after prophylactic mastectomy	PA only after prophylactic mastectomy	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
Breast reconstructive surgery—prior approval required	yes	19316	Mastopexy
		19318	Reduction mammoplasty
		19325	Mammoplasty, augmentation; with prosthetic implant
		19328	Removal of intact mammary implant
		19330	Removal of mammary implant material

Type of Surgery	PA Required	Procedure Code	Description	
		19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	
		19364	Breast reconstruction with free flap	
		19366	Breast reconstruction with other technique	
	yes		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
	yes		19380	Revision of reconstructed breast
Nipple tattooing	yes	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	

#### D. Modifiers

Providers are required to follow applicable modifier guidelines.

#### E. Billing Units

The procedure codes documented in Section C are billed as one unit per day (with modifiers as appropriate.)

#### F. Place of Service

Inpatient hospital, Outpatient hospital, Office

#### G. Co-payments

Recipients do not pay co-payments for Breast Surgeries

#### H. Reimbursement Rate

Providers must bill their usual and customary charges.