

Diagnostic and Therapeutic Breast Procedures

Benefit Criteria to Change for Diagnostic and Therapeutic Breast Procedures

Effective for dates of service on or after January 1, 2016, benefit criteria for diagnostic and therapeutic breast procedures will change for Texas Medicaid.

Diagnostic, mastectomy and breast reconstruction procedures may be benefits of Texas Medicaid.

These are physician-directed services including, but not limited to diagnostic and surgical breast procedures provided by physicians in the office, outpatient, or inpatient hospital settings, and breast prostheses provided by durable medical equipment (DME) providers in the home setting.

Categories of service include:

- Diagnostic breast procedures
- Mastectomy
- Reconstructive breast procedures
- Treatment of complications of breast reconstruction
- External breast prostheses

Diagnostic Procedures

Diagnostic breast procedures for a condition or malignancy of the breast may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy
- Nipple exploration
- Excision of the following:
 - Lactiferous duct fistula
 - Benign or malignant breast lesion
 - Chest wall tumor

Therapeutic Procedures

Mastectomy Procedures

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy) may be benefits when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect

- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

Prophylactic Mastectomy

Prophylactic mastectomy may be a benefit after a thorough assessment of a client's unique risk factors, health, and the level of concern. Prophylactic mastectomy is limited to clients who are at moderate-to-high risk for the development of breast cancer

Moderate- to high-risk clients are those who meet one or more of the following criteria for development of breast cancer:

- Current or previous diagnosis of breast cancer
- Family history of breast cancer in mother, sister, or daughter, especially before the age of 50
- Presence of any of the following genetic mutations:
 - Breast cancer gene 1 (BRCA1)
 - Breast cancer gene 2 (BRCA2)
 - Tumor protein 53 (TP 53)
 - Phosphatase and tensin homolog (PTEN)
- Lobular carcinoma in situ (LCIS)
- Radiation therapy to the chest before a client reaches 30 years of age

Mastectomy for Pubertal Gynecomastia

Mastectomy for pubertal gynecomastia may be a benefit with prior authorization for males who are 20 years of age and younger.

Breast Reconstruction

Breast reconstruction may be a benefit when all of the following criteria are met. Breast reconstruction may be performed in a single stage or several stages.

The client has a documented history of one or more of the following:

- Mastectomy
- Congenital defect
- Developmental abnormality
- Trauma or injury to the chest wall
- The client meets age and gender criteria for the requested procedure
- The physician has documented a treatment plan in the client's medical record that addresses the recommended breast reconstruction.
- Reconstruction to attain symmetry is required and may include a surgical procedure to the contralateral breast and may be either a reduction or an augmentation

Procedure options for breast reconstruction following a mastectomy include, but are not limited to the following:

- Superficial inferior epigastric artery (SIEA) flap
- Deep inferior epigastric artery (DIEP) flap
- Transverse rectus abdominis myocutaneous (TRAM) flap
- Breast implants (saline or silicone)
- Reduction mammoplasty
- Mastopexy
- Reconstruction of the nipple or areola (small flaps)
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

External Breast Prostheses

External breast prostheses are available through a durable medical equipment (DME) provider for a female client with a history of a medically necessary mastectomy procedure.

Replacement of external breast prostheses may be considered at any time, through prior authorization with documentation supporting medical necessity for the replacement.

Medicaid Breast and Cervical Cancer (MBCC)

All Medicaid services, including breast reconstruction after breast cancer surgery, are covered for Medicaid Breast and Cervical Cancer (MBCC) clients who are receiving active cancer treatment.

"Active treatment" is defined as medical treatment following a cancer diagnosis that is intended to cure or otherwise treat a diagnosed cancer.

Active treatment may include some or all of the following:

- Surgery
- Chemotherapy
- Radiotherapy
- Medication (e.g., ongoing hormonal treatments for estrogen and progesterone breast cancer)
- Active disease surveillance for triple negative receptor breast cancer

Reconstructive surgery (e.g., breast reconstruction) is considered "active treatment" if it is intended to permanently correct a physical condition resulting from either the diagnosed cancer or the treatment of the diagnosed cancer.

Ongoing treatment of a persistent condition resulting from a diagnosed cancer or treatment of a diagnosed cancer is not considered "active treatment" if cancer is no longer present or in need of treatment.

Prior Authorization Requirements (Fee-For-Service (FFS))

Prior authorization is not required for the following when all of the following criteria are met:

- The procedure is a mastectomy or breast reconstruction for clients 18 year of age or older as outlined in this policy.
- The request is for one of following external breast prosthesis procedure codes: L8000, L8001, L8002, L8010, L8015, L8020, or L8030.
- The procedure is for partial mastectomy procedure codes 19301 and 19302 for clients of any age.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client is 17 years of age or younger, or does not meet gender criteria as outlined in this policy
- Mastectomy for pubertal gynecomastia
- Procedure code 19499 (unlisted procedure)
- External breast prosthesis procedure codes L8035 (custom prosthesis) and L8039 (other prosthesis)
- Any request for new or replacement external breast prosthesis outside of the limitations.

Mastectomy for Pubertal Gynecomastia

The following documentation must be submitted with the prior authorization request for procedure code 19300:

- The gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.
- Evidence that puberty is near completion, as indicated by the following:
 - 95 percent of adult height based on bone age
 - Tanner stage V has been achieved
- Evidence that the client has been off gynecomastia inducing drugs or other substances for a minimum of one year when this has been identified as the cause of the gynecomastia.
- Evidence of resolution as supported by appropriate test results and treatment for hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas, and hypogonadism, for a minimum of one year when identified as the cause of the gynecomastia.
- Evidence of a psychiatric assessment performed by a psychiatrist or psychologist.
- Client's history and treatment plan including planned surgical procedure and timelines.
- Identification of which breast or breasts, require mastectomy.

Unlisted Breast Procedure

The following documentation must be submitted for procedure code 19499 with the prior authorization request:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code, which is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental

- Place of service the procedure is to be performed
- The provider's intended fee for this procedure.

External Breast Prostheses

For a new or replacement external breast prosthesis procedure code outside the limitations outlined in this policy, the following documentation must be submitted with the prior authorization request.

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8035 (custom prosthesis), the following documentation must be submitted with the prior authorization request;

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8039 (other prosthesis), the following documentation must be submitted with the prior authorization request;

- A clear, concise description of the breast prosthesis requested
- Reason for recommending the requested prosthesis
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation that this breast prosthesis is not investigational or experimental
- The provider's intended fee for the requested prosthesis.

Reimbursement/Billing Guidelines

Providers must use the appropriate procedure code(s) and modifier(s) to submit claims.

The following procedure codes may be reimbursed for diagnostic and therapeutic breast procedures, and external breast prostheses:

Services	Procedure Codes	Additional Information
Diagnostic procedures	19000, 19001, 19020, 19030, 19081, 19082, 19083, 19084, 19085, 19086, 19100, 19101, 19110, 19112, 19120, 19125, 19126, 19281, 19282, 19283, 19284, 19285, 19286, 19287, 19288	N/A
Mastectomy	19301*, 19302*, 19303*, 19304*, 19305*, 19306*, 19307*	Prior authorization is required when the client does not meet gender or age criteria for procedure codes 19303,

Services	Procedure Codes	Additional Information
		19304, 19305, 19306, 19307.
Mastectomy for pubertal gynecomastia	19300	Prior authorization is required.
Breast reconstruction	11970**, 11971**, 19316*, 19324*, 19325*, 19340*, 19342*, 19350*, 19355*, 19357*, 19361*, 19364*, 19366*, 19367*, 19368*, 19369*, 19396*, S2068*	Procedure codes 19316, 19324, 19325, 19340, 19342, 19357 and 19396 are limited to females. Prior authorization is required when the client does not meet gender or age criteria.
Tattooing	11920*, 11921*, 11922*	Prior authorization is required when the client does not meet gender or age criteria.
Complications of breast reconstruction	19328, 19330, 19370, 19371, 19380	These procedure codes are limited to females, except for procedure code 19380.
Chest wall procedures	19260, 19271, 19272	N/A
Unlisted breast procedure	19499	Prior authorization is required.
Soft tissue reinforcement	15777	This is an add-on procedure code and must be billed with the appropriate primary procedure code.
Breast prostheses	L8000, L8001, L8002, L8010, L8015, L8020, L8030, L8031, L8032, L8035, L8039	These procedure codes are limited to females. Prior authorization is required for L8035 and L8039. Prior authorization is required for all other breast prostheses when the client does not meet gender or age criteria.

***Note:** Procedure code will no longer be diagnosis restricted. A valid and appropriate ICD-10-CM diagnosis code must be submitted on the claims.

****Note:** Procedure codes 11970 and 11971 requires prior authorization for all clients 17 years of age and younger.