

**Policy is terminated because coverage is provided under the combined
Medicaid and Health Choice 1A-12, Breast Surgeries**

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1.0 Description of the Procedure, Product, or Service

Mammoplasty is plastic reconstruction of the breast, either to augment or reduce.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC 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; **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

Mammoplasties are covered when medically necessary for the following:

- a. Plastic procedures to correct congenital unilateral absence of a breast
- b. Reconstructive breast surgery resulting from a mastectomy is covered. The coverage includes all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer or breast disease. Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery may also include augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction.

- c. Reduction mammoplasty for symptomatic breast hypertrophy may be considered medically necessary and eligible for coverage when ALL of the following criteria are met:
1. The recipient has significant symptoms that interfere with normal activities, including at least one (1) of the following:
 - (a) Symptomatic neck, back or shoulder pain not related to other causes (e.g., poor posture, acute strains, poor lifting techniques). Documentation of evaluation and treatment of neck, back or shoulder pain must be supplied.
 - (b) Inability to sleep in a reclined position due to shortness of breath
 - (c) Clinical, nonseasonal submammary intertrigo;
 2. The recipient's physical exam documents at least two (2) of the following:
 - (a) Significant shoulder grooving
 - (b) Obvious breast hypertrophy (pictures are not necessary)
 - (c) Suprasternal to nipple measurement of greater than 28 cm for women greater than or equal to 5'2" tall, or 25 cm for women less than 5'2" tall
 - (d) Physical exam is consistent with symptoms precipitating request for reduction mammoplasty;
 3. Failure of conservative measures including:
 - (a) for back, neck, or shoulder pain, failure of six (6) weeks of conservative treatment, including ALL of the following:
 - i. Appropriate support bra;
 - ii. NSAIDS (if not contraindicated); **AND**
 - iii. Exercises and heat or cold application
 - (b) for submammary intertrigo, six (6) weeks of conservative treatment, including ALL of the following:
 - i. appropriate hygiene;
 - ii. appropriate medical/pharmacologic treatment; **AND**
 - iii. utilization of an appropriate support bra.
 4. For recipients with a Body Mass Index (BMI) greater than 27, a documented and legitimate medically based attempt to reduce and maintain weight. This requirement relates specifically to recipients with low back pain and intertrigo, where obesity is a documented risk factor. In the absence of weight loss to a BMI less than or equal to 27, a legitimate attempt at weight loss includes **ALL** of the following:
 - (a) Initial consultation with a physician or advanced practice practitioner (Nurse Practitioner, Physician's Assistant) regarding weight loss; **AND**

- (b) The weight loss attempt includes **ALL** of the following:
- i. Regular visits with a practitioner, nutritionist, or other recognized weight loss program over three (3) months;
 - ii. The weight loss program includes reasonable dietary modifications and appropriate aerobic exercise; **AND**
 - iii. The record indicates that the recipient has made reasonable attempts to comply with the weight loss program.

AND

5. Proposed surgery is anticipated and documented to remove a clinically significant amount of tissue based on body surface area. Refer to **Attachment B** for a table calculating the appropriate amount of breast tissue based on body surface area.

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

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, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. Augmentation or reduction mammoplasties performed solely for cosmetic purposes, are not covered.
- b. Services received in treatment of complications due to previously performed cosmetic procedures are not covered.
- c. Augmentation mammoplasty for small breasts is not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for mammoplasties.
- b. A letter of medical necessity signed and dated by the surgeon must be submitted to DMA's vendor prior to rendering the surgery.
- c. Documentation must include:
 1. Recipient's NCHC ID number.

2. Recipient's mailing address.

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 NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **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

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.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
5/31/12	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Codes			
19316	19318	19324	19325

Note: Append for medical

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital and ASC

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.

Attachment B: Schnur Sliding Scale

The weight of breast tissue anticipated to be removed or removed must be greater than the threshold value for a given body surface area (BSA) in order to be considered medically necessary. Refer to Schnur Sliding Scale, below.

Body surface area may be calculated by using the following formula:

$$BSA (m^2) = ([Height(in) \times Weight(lbs)] / 3131)^{1/2}$$

Schnur Sliding Scale

Body surface area (in meters squared)	Threshold of breast tissue to be removed (in grams) from each breast
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

Adapted from: Schnur, Paul L, et al., "Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?"
Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7.