
CHAPTER 5: PROFESSIONAL SERVICES

SECTION 5.1: COVERED SERVICES**PAGE(S)****56**

Breast Surgery**Breast Reconstruction Post Mastectomy**

~~Effective with dates of service October 1, 2016 and forward,~~ Louisiana Medicaid considers reconstructive breast surgery medically necessary after a mastectomy or a lumpectomy that results in a significant deformity (i.e., mastectomy or lumpectomy for treatment of breast cancer). Reconstruction of the affected/diseased breast and the contralateral unaffected breast to achieve symmetry is considered medically necessary.

Breast reconstruction is covered for recipient beneficiaries who have a mastectomy with a diagnosis of breast cancer. Mastectomy includes:

- Partial (lumpectomy, tylectomy, quadrantectomy and segmentectomy);
- Simple;
- Modified radical; and
- Radical.

Breast reconstruction surgery is often considered after a mastectomy to correct deformity or reestablish symmetry caused by previous surgery and/or the effects of therapeutic treatments. Reconstruction procedures may involve multiple techniques and stages to recreate the breast mound through the use of prosthetic implants, tissue flaps or autologous tissue transfers, as well as nipple/areola reconstruction.

The following services are covered:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including nipple tattooing;
- Prosthesis (Implanted and/or external); and
- Treatment of physical complications of the mastectomy.

CHAPTER 5: PROFESSIONAL SERVICES

SECTION 5.1: COVERED SERVICES**PAGE(S)**56

Clinical Guidelines and Criteria

Louisiana Medicaid bases its determination of medical necessity for breast reconstruction on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure, including post-operative recovery. These include, but are not limited to, the following:

- A comprehensive medical history and physical exam has been conducted by a physician to evaluate the need for breast reconstruction surgery;
- The breast reconstruction surgery is intended to correct, restore or improve anatomical and/or functional impairments that result from therapeutic interventions (i.e., radiation) or disease of the breast;
- A surgical treatment plan that outlines the type of techniques and stages of the procedure(s) that will be performed has been developed; and
- The proposed surgery follows a mastectomy that has been performed to remove a malignant neoplasm or carcinoma in situ of the breast.

Covered Procedures

The following procedures for breast reconstruction following mastectomy or lumpectomy will be covered if prior authorized:

- Breast reconstruction procedures performed on the diseased/affected breast (i.e., breast on which the mastectomy/lumpectomy was performed), including:
 - Areolar and nipple reconstruction;
 - Areolar and nipple tattooing;
 - Autologous fat transplant (i.e., lipoinjection, lipofilling, lipomodeling);
 - Breast implant removal and subsequent re-implantation;
 - Capsulectomy;

CHAPTER 5: PROFESSIONAL SERVICES

SECTION 5.1: COVERED SERVICES**PAGE(S)**56

- Capsulotomy;
- Implantation of tissue expander;
- Implantation of U.S. Food and Drug Administration (FDA)-approved internal breast prosthesis;
- Oncoplastic reconstruction;
- Reconstructive surgical revisions; and
- Tissue/muscle reconstruction procedures (e.g., flaps), including, but not limited to, the following :
 - Deep inferior epigastric perforator (DIEP) flap;
 - Latissimus dorsi (LD) myocutaneous flap;
 - Ruben's flap;
 - Superficial inferior epigastric perforator/artery (SIEP/SIEA) flap ;
 - Superior or inferior gluteal free flap;
 - Transverse rectus abdominus myocutaneous (TRAM) flap; and
 - Transverse upper gracilis (TUG) flap.
- Breast reconstruction procedures performed on the non-diseased, unaffected, contralateral breast, in order to produce a symmetrical appearance, including:
 - Areolar and nipple reconstruction;
 - Areolar and nipple tattooing;
 - Augmentation mammoplasty;

CHAPTER 5: PROFESSIONAL SERVICES

SECTION 5.1: COVERED SERVICES**PAGE(S)**56

- Augmentation with implantation of FDA-approved internal breast prosthesis when the unaffected breast is smaller than the smallest available internal prosthesis ;
- Autologous fat transplant (i.e., lipoinjection, lipofilling, lipomodeling);
- Breast implant removal and subsequent reimplantation when performed to produce a symmetrical appearance;
- Breast reduction by mammoplasty or mastopexy;
- Capsulectomy;
- Capsulotomy; and
- Reconstructive surgery revisions to produce a symmetrical appearance.

Reconstruction of the contralateral unaffected breast to achieve symmetry, including tattooing to correct color defects of the skin is limited to clients with a documented history of a breast reconstruction performed within the past 12 months. The breast reconstruction must have been performed while the recipient/beneficiary was eligible for Louisiana Medicaid.

Prior Authorization

Breast reconstruction post mastectomy of the affected/diseased breast, and the contralateral unaffected breast to achieve symmetry must be prior approved by the fiscal intermediary's Prior Authorization Unit (PAU) or the managed care organization (MCO).

Prior authorization (PA) requests to the fiscal intermediary's PAU should include the following:

- PA request form;
- Documentation of medical necessity, to include all of the following:
 - The primary diagnosis name and ICD-CM codes for the condition requiring reconstruction;
 - The secondary diagnosis name(s) and ICD-CM code(s) pertinent to comorbid condition(s);

CHAPTER 5: PROFESSIONAL SERVICES

SECTION 5.1: COVERED SERVICES

PAGE(S)

56

- The most recent medical evaluation, including a summary of the medical history and last physical exam;
- Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma in situ of the breast;
- Risk factors or comorbid conditions;
- Surgical treatment plan, including a description of the type of tissue flaps and/or prosthetic implant(s) to be used. Where the procedure requires an implant, the implant must be FDA-approved; and
- Other pertinent clinical information that may be requested.

Clinical information must be submitted by the surgeon involved in the recipient/beneficiary's care.

~~The documentation required for PA requests to the MCO shall be determined by the MCO. Managed care organizations will utilize the criteria they deem appropriate for breast reconstruction based upon the clinical information submitted by the surgeon involved in the recipient's care.~~

Reimbursement

Breast reconstruction surgery is reimbursed for the *Current Procedural Terminology* (CPT) codes currently approved for the reimbursement of reconstructive breast surgery services to physicians and in accordance with the current regulations of the Professional Services Program. Information regarding the fee schedule to be used for breast reconstructive surgery services can be obtained on Louisiana Medicaid website following the links under “Fee Schedule,” “Professional Services Fee Schedule”.

Reduction Mammoplasty and Removal of Breast Implants

Reduction mammoplasty must be considered medically necessary.

The beneficiary must meet the following weight and height criteria before the provider is to submit a request for evaluation and consideration for reduction mammoplasty services. The patient's total weight shall not exceed twenty percent of the weight limit established by the following formula.

<u>Height</u>	<u>Pounds</u>
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CHAPTER 5: PROFESSIONAL SERVICES

SECTION 5.1: COVERED SERVICES

<u>5 feet</u>	<u>100</u>
<u>Each additional inch over 5 ft.</u>	<u>5</u>

Examples:

- A request for reduction mammoplasty services shall not be submitted for consideration for an enrollee who is 5 feet tall and weighs more than 120 pounds (100 pounds * 120%).
- An enrollee who is 5 feet, one inch tall shall weigh no more than 126 pounds (105 pounds * 120%) to be considered.
- An enrollee who is 5 feet, 5 inches tall shall weigh no more than 150 pounds (125 pounds * 120%) to be considered.

Prior Authorization

When the qualifying condition stated above is met, providers may then submit a request for prior authorization for reduction mammoplasty upon which the determination of medical necessity will be made.

When medically necessary, Louisiana Medicaid reimburses the removal of breast implants.