ND

Medical Policies

Print

Policy Number:	S-163		
Policy Name:	Prophylactic Mastectomy		
Policy Type:	Medical	**Policy Subtype:**	Surgery
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Prophylactic mastectomy is defined as the removal of the breast in the absence of malignant disease. Prophylactic mastectomies may be performed in women considered at high risk of developing breast cancer, either due to a family history, presence of a BRCA1, BRCA2, TP53, PTEN, PALB2, CDH1, STK11 gene mutation, or another gene variant associated with high risk; or the presence of lesions associated with an increased cancer risk.

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Criteria

Coverage is subject to the specific terms of the member's benefit plan.

Prophylactic mastectomy may be considered medically necessary when **ONE** or more of the following risk factors are present:

- Those with a strong family history of breast cancer such as:
    - A family history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (family cancer syndrome); **and**

    - The individual's risk of breast cancer is elevated on a validated assessment tool such as the Breast Cancer Risk Calculator, Gail Model, or Tyrer-Cuzick Risk Calculator; **and**
    - The individual has undergone counseling form an appropriate provider such as gynecologist, breast surgeon or genetic counselor to quantitate their risk; **or**
- Individual has tested positive for BRCA1, BRCA2, TP53, PTEN, PALB2 , CDH1, STK11 gene mutations; or another gene variant associated with high risk; **or**
- High-risk histology: Atypical ductal or lobular hyperplasia, or lobular carcinoma in situ confirmed on biopsy; **or**
- Individuals with such extensive mammographic abnormalities (e.g., calcifications), cystic/dense breast tissue) that adequate biopsy is impossible; **or**
- Individuals with a personal history of breast cancer making it more likely to develop a new cancer in the opposite breast; **or**
- Individuals who received radiation therapy to the thoracic region before the age of 30 (e.g. radiation to treat Hodgkin's disease) **.**

Mastectomy of the contralateral breast may be considered medically necessary when **ONE** or more of the following situations exists:

- For risk reduction in individuals at high risk for a contralateral breast cancer as stated above; **or**
- For individuals in whom subsequent surveillance of the contralateral breast would be difficult such as for:
    - Dense breast tissue as shown clinically or mammographically; **or**
    - Diffuse and/or indeterminate calcifications; or
- For improved symmetry in individuals undergoing mastectomy with reconstruction for the index cancer who:
    - Have a large and/or ptotic contralateral breast; **or**
    - Disproportionately sized contralateral breast.

Coverage for reconstructive breast surgery is provided for individuals undergoing covered prophylactic mastectomies.

Prophylactic mastectomy for any other reason is considered not medically necessary.

Procedure Code

19303

Diagnosis Codes

Covered Diagnosis Codes for Procedure Code 19303

D05.00	D05.01	D05.02	D05.10	D05.11	D05.12	D05.80
D05.81	D05.82	D05.90	D05.91	D05.92	E71.440	R92.1
R92.8	Z15.01	Z17.410	Z17.420	Z40.01	Z80.3	Z85.3

CURRENT CODING

CPT:

19303	MASTECTOMY SIMPLE COMPLETE	Medicaid Expansion
19303	MASTECTOMY SIMPLE COMPLETE	Commercial

References

1. InterQual® Level of Care Criteria. 2018. Acute Care Adult. McKesson Health Solutions,
2. Honold F, Camus M. Prophylactic mastectomy versus surveillance for the prevention of b6-reast cancer in women's BRCA carriers. *Medwave*. 2018;18(4):e7161.
3. Jakub JW, Peled AW, Gray RJ, et al. Oncologic safety of prophylactic nipple- sparing mastectomy in a population With BRCA Mutations: A multi- institutional study. 2018;153(2):123-129.
4. Hegde J, Wang X, Attai D, Di Nome M, et al. Assessing the effect of lifetime contralateral breast cancer risk on the selection of contralateral prophylactic mastectomy for unilateral breast cancer. *Clin Breast Cancer.* 2018;18:E205- E218.
5. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High- Risk Assessment: Breast and Ovarian. Version 3.2019.
6. Teoh V, Tasoulis M, and Gui G. Contralateral Prophylactic Mastectomy in women with unilateral breast cancer who are genetic carriers, have a strong family history or are just young at presentation. *Cancers.* 2020;12:140.
7. Bouchard-Fortier N, Baxter N, Sutradha R, Fernandes K, Camacho X, Graham P, and Quan M. Contralateral prophylactic mastectomy in young women with breast cancer: a population-based analysis of predictive factors and clinical impact. *Curr Oncol.* 2018;6:e562-e568.
8. The American Society of Clinical Oncology(ASCO), The American Society for Radiation Oncology (ASTRO), and Society of Surgical Oncology (SSO). *Management of Hereditary Breast Cancer: American Society of Clinical Oncology, American Society for Radiation Oncology, and Society of Surgical Oncology Guideline.* J Clin Oncol. 2020 20;38(18):2080-2106.
9. McCarthy AM, Guan Z, Welch M, et al. Performance of breast cancer risk- assessment models in a large mammography cohort. *J Natl Cancer Inst.* 2020; 112(5): 489-497.
10. Tischkowitz M, Balmaña J, Foulkes WD, et al. Management of individuals with germline variants in PALB2: a clinical practice resource of the American College of Medical Genetics and Genomics (ACMG). *Genet Med*. 2021;23(8):1416-1423.
11. Aslam A, Arshad Z, Ahmed A, et al. Bilateral risk-reducing mastectomy and reconstruction- a 12-year review of methodological trends and outcomes at a tertiary referral centre. *PLOS ONE*. 2023;18(4): e0281601. https://doi.org/10.1371/journal.pone.0281601.

ND Committee Review

Internal Medical Policy Committee 9-26-2019 Coding update

Internal Medical Policy Committee 5-19-2020 Annual Review

Internal Medical Policy Committee 11-19-2020 wording changes

Internal Medical Policy Committee 11-23-2020 Annual Review-no changes in criteria

Internal Medical Policy Committee 3-23-2022 Revision

- *Update* in criteria and clarifying language

Internal Medical Policy Committee 3-23-2023 Annual Review-no changes in criteria

Internal Medical Policy Committee 7-26-2023 Revision

- *Updated* language throughout policy
  - *Added* CDH1, STK11 gene mutations or another gene variant associated with high risk'.

Internal Medical Policy Committee 7-16-2024 Annual Review-no changes in criteria

- *Added* coverage statement; and
- *Added* Policy Application

Internal Medical Policy Committee 9-17-2024 Coding update- Effective October 01, 2024

- *Added* diagnosis codes Z17.410 and Z17.420

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.