To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

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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 beneficiaries 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 Mammaplasty

Reduction mammaplasty 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 mammaplasty, 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.

1.6 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

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

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

b. <u>NCHC</u>
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when 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 beneficiary'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 beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

a. Mastectomy

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

1. Malignant neoplasm of the breast.
2. Secondary malignant neoplasm of the breast.
3. Carcinoma in situ of the breast.

b. Mastectomy for Male Gynecomastia

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

1. An adult beneficiary has a history of gynecomastia that persists for more than 3 to 4 months after pathological causes are ruled out.
2. An adolescent's gynecomastia persists more than 6 months after pathological causes are ruled out.
3. The excessive tissue is glandular and not fatty tissue as confirmed by clinical exam, and either ultrasound or mammogram.
4. Other causes of gynecomastia such as obesity, adolescence, and drug treatments (gynecomastia resolves with the discontinuation of the medication) have been ruled out.
5. 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).
6. The beneficiary's body mass index (BMI) is less than or equal to 30 (http://www.halls.md/ideal-weight/body.htm)
7. The beneficiary has a documented history of significant medical symptoms due to the gynecomastia that are not resolved by conservative treatments.

c. Prophylactic Mastectomy

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

1. Breast biopsy indicates that the beneficiary 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**
2. Personal history of breast cancer (invasive ductal, invasive lobular, or ductal carcinoma-in-situ) in the contralateral breast and/or personal positive BRCA1or BRCA2 genetic testing **OR**
3. 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:

1. Family history strongly suggestive of an autosomal dominant pattern of inheritance of a genetic mutation predisposing to breast cancer and/or ovarian cancer.
2. Immediate family history of breast cancer (mother, sister, daughter, brother, father).
3. Personal history of ovarian cancer or history of a first-degree relative with ovarian cancer.
4. 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.

d. Reduction Mammaplasty

Unilateral reduction mammaplasty 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 3.2.1.e.**

Reduction mammaplasty is only covered when performed as a part of a reconstructive surgery that meets the requirements as outlined in **Subsection 3.2.1.e**.

e. Breast Reconstructive Surgery

1. 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:
   A. Malignant neoplasm of the breast.
   B. Secondary malignant neoplasm of the breast.
   C. Carcinoma in situ of the breast, either lobular or ductal.
   D. Congenital absence of the breast (Poland's syndrome).
   E. Prophylactic mastectomy when the criteria listed in **Subsection 3.2.1.c** are met.
2. 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.

3. 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.

f. Policy Guidelines for Breast Reconstruction Surgery

The policy guidelines for breast reconstructive surgery are as follows:

1. Breast reconstruction, including implant material, is limited to once per occurrence of breast cancer.
2. 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.
3. 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.
4. If the reconstruction is to follow a prophylactic mastectomy, prior approval must be obtained.

Note: The best candidates for breast reconstructive surgery are those whose cancer can be adequately treated by mastectomy plus or minus adjuvant therapy including chemotherapy and radiation therapy. The presence or absence of metastatic disease is not the controlling factor in whether a candidate is an appropriate candidate for breast reconstructive surgery.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall 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 mammaplasty 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 augmentation.
g. Breast reduction except when the criteria in **Subsection 3.2.1.d** are met.
h. Mastopexy except when the criteria in **Subsection 3.2.1.e** are met.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for certain breast surgeries.

Refer to **Attachment A, Section C, Code(s).**

Mastectomy for Breast Cancer

Mastectomy for breast cancer does not require prior approval.

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 beneficiary'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.

Prophylactic Mastectomy

Prophylactic mastectomy requires prior approval. The requesting physician shall 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 3.2.1.c.**
d. Plan of treatment, including any planned reconstruction.

Reduction Mammaplasty

Reduction mammaplasty requires prior approval when performed as part of reconstructive surgery that meets requirements as outlined in **Subsection 3.2.1.e.**

Breast Reconstructive Surgery

Certain breast reconstructive surgeries require prior approval. Refer to **Attachment A, Section C, Code(s).**

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Breast Reconstruction Requirements

Certain breast reconstructive procedures require prior approval. In addition to Prior Approval Requirements listed in **Subsection 5.2**, 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.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s)..

7.2 FDA Approval

FDA-approved prosthetic implants shall 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, shall be retained in the beneficiary's office medical record and shall be available for review upon request.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1999

Revision Information:

10/01/2004	Section 1.0	The definition was modified to include reduction mammaplasty of the non-diseased breast to achieve symmetry following a medically necessary mastectomy; prophylactic mastectomy; and mastectomy for male gynecomastia.
10/01/2004	Section 3.0	Coverage criteria for prophylactic mastectomy and mastectomy for male gynecomastia was added.
10/01/2004	Section 3.3.5	Personal positive BrCA1and BrCA2 genetic testing added.
10/01/2004	Sections 3.5, 5.5, 8.3.5	Added information about reconstruction after prophylactic mastectomy.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/01/2006	Sections 2 through 5	A special provision related to EPSDT was added.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
07/01/2008	Section 1.3	Clarified that fibrocystic disease alone is not a legitimate reason for mastectomy.
07/01/2008	Section 1.5	Added detail to description of breast reconstruction.
07/01/2008	Section 2.2	Added legal citation.
07/01/2008	Section 3.1	Added section on general criteria for coverage.
07/01/2008	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.
07/01/2008	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.

07/01/2008	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.
07/01/2008	Section 3.6	Substituted "mastopexy and/or augmentation" for "mammaplasty."
07/01/2008	Section 4.1	Updated standard statement of noncoverage.
07/01/2008	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."
07/01/2008	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.
07/01/2008	Section 5.3	Added requirement for plan of treatment to specify planned reconstruction.
07/01/2008	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.
07/01/2008	Section 5.5.1	Added URL for Web site of American Society of Plastic Surgeons.
07/01/2008	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.
07/01/2008	Section 5.5.3	Specified that coverage is limited to once per cancer occurrence and that cosmetic implant replacement is not covered.
07/01/2008	Section 7.1	Set this section off from EPSDT language.
07/01/2008	Section 7.2	Added standard statement about records retention.
07/01/2008	Section 7.3	Added standard statement about federal and state requirements.
07/01/2008	Section 8.0	Moved billing guidelines to Attachment A, Claims-Related Information.
07/01/2008	Attachment A, A	Updated claim type to standard language.
07/01/2008	Attachment A, B	Added fourth digit to 175 range; corrected code descriptions throughout.

07/01/2008	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.
07/01/2010	All sections and attachment(s)	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
12/01/2010	Subsection 2.0	Updated Web site links
12/01/2010	Subsection 3.1	Updated to standard policy language
12/01/2010	Subsection 3.2.4	Deleted General Criteria for Reduction Mammaplasty
12/01/2010	Subsection 4.2	Added h. mastopexy except when the criteria in Subsection 3.2.5 are met
12/01/2010	Subsection 5.1.4	Deleted a., c., and d, and left Subsection wording to read: "Unilateral reduction mammaplasty 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."
12/01/2010	Subsection 6.0	Updated to standard policy language
12/01/2010	Subsection 7.0	Updated to standard policy language
12/01/2010	Attachment A	B. Deleted Reduction Mammaplasty - type of surgery, diagnosis code and description Added Reduction mammaplasty on a contralateral breast - type of surgery, diagnosis code and description
12/01/2010	Attachment A	Added claim type, modifiers, billing units, place of service, co pays
06/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
06/15/2012	Header	Revised Date corrected in header
09/12/2012	Subsection 3.2.6	Deleted according to the American Society of Plastic Surgeons and (http://www.plasticsurgery.org/patients_consumers/procedures/BreastReconstruction.cfm).
01/15/2013	Subsection 3.2.6	Deleted women as far as determined, seems to have been eliminated by mastectomy. It is understood that patients with known metastasis would not be candidates for reconstruction.
01/15/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-Code(s)			
C50.011	C50.319	C50.622	D05.12
C50.012	C50.321	C50.629	D05.80
C50.019	C50.322	C50.811	D05.81
C50.021	C50.329	C50.812	D05.82
C50.022	C50.411	C50.819	D05.90
C50.029	C50.412	C50.821	D05.91
C50.111	C50.419	C50.822	D05.92
C50.112	C50.421	C50.829	D48.60
C50.119	C50.422	C50.911	D48.61
C50.121	C50.429	C50.912	D48.62
C50.122	C50.511	C50.919	D49.3
C50.129	C50.512	C50.921	N62
C50.211	C50.519	C50.922	N65.1
C50.212	C50.521	C50.929	Z80.3
C50.219	C50.522	C79.81	Z80.8
C50.221	C50.529	D05.00	Z84.89
C50.222	C50.611	D05.01	Z85.3
C50.229	C50.612	D05.02	
C50.311	C50.619	D05.10	
C50.312	C50.621	D05.11	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

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

Continued

Type of Surgery	PA Required	Procedure Code	Description
Breast reconstructive surgery—prior approval required	yes	19316	Mastopexy
		19318	Reduction mammaplasty
		19325	Mammaplasty, augmentation; with prosthetic implant
		19328	Removal of intact mammary implant
		19330	Removal of mammary implant material
		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

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers

Providers shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient hospital, Outpatient hospital, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/