BlueCross BlueShield of Arizona
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MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

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MASTECTOMY FOR THE TREATMENT OF FIBROCYSTIC BREAST DISEASE

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

Description:

Mastectomy is the surgical removal of a breast.

Total Mastectomy:
Removal of the majority of glandular breast tissue, some skin, and the nipple-areolar complex with preservation of the lymphatic drainage system.

Subcutaneous Mastectomy:
Removal of the majority of the glandular breast tissue with preservation of the skin, nipple, areola and lymphatic drainage system.

Definitions:

1st Degree Relative:
Blood-related sibling, parent or child.

MASTECTOMY FOR THE TREATMENT OF FIBROCYSTIC BREAST DISEASE (cont.)

Criteria:

- Mastectomy for the treatment of fibrocystic breast disease is considered ***medically necessary*** with documentation of **ALL** of the following:

  1. Fibrocystic breast disease diagnosed by **ONE** or more of the following:

     - Progressive pain and breast changes with periods
     - Discharge from nipples
     - Persistent and/or recurrent nodules or cysts
     - Mammographic changes or increase in number of cysts or fibrosis over a one year period

  2. Diagnosis of fibrocystic breast disease and **ONE** of the following:

     - Severe pain requiring prescription pain medication
     - Resistance to treatment with documentation of **ONE** or more of the following:

       - Hormonal therapy
       - Multiple biopsies
       - Multiple aspirations
       - Symptoms persist one year or longer
       - Symptomatic care failure (e.g., dietary changes, analgesics, heat, etc.) for one year or longer

     - Dense, fibronodular breasts that are difficult to evaluate mammographically or clinically in association with **ONE** or more of the following:

       - BRCA1/BRCA2 gene mutation confirmed by genetic testing
       - History of first degree relative with breast cancer documented by **ONE** of the following:

         a. 2 or more 1st degree relatives with unilateral breast cancer
         b. 1 or more 1st degree relative with bilateral breast cancer
         c. 1 or more 1st degree relative with premenopausal breast cancer

MASTECTOMY FOR THE TREATMENT OF FIBROCYSTIC BREAST DISEASE
(cont.)

Resources:

1. American Cancer Society. Fibrocystic Breasts: A Non-Disease.
2. American Society of Plastic Surgeons Position Statement. Prophylactic Mastectomy. June 1994.
3. InterQual® Care Planning Criteria, Procedures Adult. Mastectomy, Total/Simple.
4. National Cancer Institute. Preventive Mastectomy. 2001.
5. Society of Surgical Oncology. Position Statement on Prophylactic Mastectomy. March 2001.