



Risk Reduction and Contralateral Prophylactic Mastectomy

I. Policy

University Health Alliance (UHA) will reimburse for prophylactic mastectomy when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

- A. Prophylactic mastectomy is covered (subject to Administrative Guidelines) in patients at high risk of breast cancer, defined as having one or more of the following:
 - 1. Lobular carcinoma in situ
 - 2. A known BRCA1 or BRCA2 mutation
 - 3. Another gene mutation associated with high risk e.g., TP53 (Li-Fraumeni syndrome), PTEN (Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome), CDH1, and STK11.
 - 4. High risk (lifetime risk about 20% or greater) of developing breast cancer as identified by models that are largely defined by family history.
 - 5. Received radiation therapy to the chest between the ages of 10 and 30 years.
- B. Prophylactic mastectomy is covered (subject to Administrative Guidelines) in patients with such extensive mammographic abnormalities (i.e., calcifications) that adequate biopsy or excision is impossible.
- C. It is strongly recommended that all candidates for risk-reducing mastectomy undergo counseling regarding cancer risks from a healthcare professional skilled other than the operating surgeon to assess cancer risk and to discuss various treatment options, including increased surveillance or chemoprevention.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

- A. Prophylactic mastectomy is not covered for all other indications, including but not limited to contralateral prophylactic mastectomy in women with breast cancer who do not meet high risk criteria as it is not known to be effective in improving health outcomes and is discouraged by the American Society of Breast Surgeons for average risk women with unilateral breast cancer.

- B. Providers should be aware of the position statement rendered by the American Society of Breast Surgeons and should discuss it with patients considering prophylactic mastectomy.
- C. UHA requires an informed consent discussion which addresses the potential for contralateral or any prophylactic mastectomy to result in complications which can (particularly with CPM) forestall or affect necessary adjuvant or other therapies. The doubling of risks for complications should be explicitly described and the absence of improved overall survival except in narrow categories must be integral to counselling.

IV. Administrative Guidelines

- A. Prior authorization is required.
- B. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.
- C. Applicable Codes:

CPT Code	Description
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous

V. Policy History

Policy Number: MPP-0035-120301
Current Effective Date: 08/10/2021
Original Document Effective Date: 03/01/2021
Previous Revision Dates: 09/01/2016, 11/27/2018
PAC Approved Date: 03/01/2012