



Prophylactic Mastectomy

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Purpose:

To provide prophylactic mastectomy guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Additional Information

- Prophylactic mastectomy is one (1) option for women considered to be at high risk for occurrence or reoccurrence of breast cancer. It appears to reduce but not eliminate breast cancer risk although the actual degree of risk reduction is unknown. The ultimate decision, however, to undergo this treatment option rests with the Member herself. Prophylactic mastectomy is not an urgent procedure, and the Member should take plenty of time to discuss, obtain counseling if needed, and contemplate the decision, before deciding upon this course of treatment.

Coverage Guidelines

- A prophylactic mastectomy (unilateral or bilateral) is covered for any of the following criteria:
 - 1) Previous breast cancer history including Lobular carcinoma in situ (LCIS).
 - 2) Family history of breast cancer in three (3) or more affected first- or second-degree blood relatives on the same side of the family, irrespective of age at diagnosis.
 - 3) Genetic Predisposition for any of the following:
 - a) The presence of BRCA1 or BRCA2 mutations confirmed by molecular susceptibility testing for breast and/or ovarian cancer;
 - b) A first-degree relative who carries a genetic mutation in the TP53 or PTEN genes (Li-Fraumeni syndrome and Cowden and Bannayan-Riley-Ruvalcaba syndromes);
 - c) Ethnic background with a higher risk for breast cancer (for instance: Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent) and who have one (1) or more relatives with breast cancer or ovarian cancer at any age.
 - 4) History of diffused and indeterminate breast microcalcifications or dense breasts as evidenced by physical examination and mammography.
 - 5) Radiation therapy to the chest before age 30.

References:

1. National Cancer Institute – www.cancer.gov - Preventative Mastectomy section.
2. American Society of Plastic Surgeons. Executive Committee recommendations 2003. Prophylactic Mastectomy.
3. American Cancer Society. Breast Cancer Facts and Figures 2005-2006. 2005.
4. HAYES Medical Technology Directory™. Prophylactic Mastectomy. 2002 Sep.
5. Society of Surgical Oncology. Position statement on prophylactic mastectomy. Approved 2001.



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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.