



Corporate Medical Policy

Breast Surgeries

File Name: breast_surgeries
Origination: 1/2000
Last Review: 8/2004

Active policy, no longer scheduled for routine literature review.

Description of Procedure or Service

Mastectomy is a surgical removal of all or a part of the breast. It is generally performed as treatment for breast cancer or breast disease. When a member certificate covers mastectomy, BCBSNC also covers reconstructive breast surgery resulting from the mastectomy. Procedures or services described in this policy include the following:

- ◆ **Section I** -Reconstructive breast surgery after mastectomy
- ◆ **Section II** -Mastectomy for gynecomastia
- ◆ **Section III** -Reduction [mammoplasty](#)
- ◆ **Section IV**-Prophylactic Mastectomy
- ◆ **Section V** - Insertion and Removal of Breast Implants.

Blue Cross and Blue Shield of North Carolina will not assign specific length of stay for patients having a mastectomy. Whether the surgery is to be inpatient or outpatient and the length of stay are decisions for the attending physician.

Benefits are available for the physical complications related to all stages of mastectomy for breast cancer, including treatment of associated lymphedema.

Policy

Active policy, no longer scheduled for routine literature review.

BCBSNC will cover Reconstructive Breast Surgery after Mastectomy, Mastectomy for Gynecomastia, Reduction Mammoplasty, Prophylactic Mastectomy, and Insertion and Removal of Breast Implants when it is medically necessary because the criteria shown below have been met.

Benefits Application

Please refer to Certificate of availability of benefits. This policy relates only to the services or supplies described herein. Benefits may vary according to benefit design, therefore certificate language should be reviewed before applying the terms of the policy

Breast surgeries included in this policy may require prior plan approval.

Section I - Reconstructive Breast Surgery - After-mastectomy

Reconstructive breast surgery is performed following a mastectomy to re-establish [symmetry](#) between the two breasts. It includes reconstruction of the mastectomy site, creation of a new breast mound and creation of a new nipple/[areolar complex](#) following removal of a breast. It may also include reconstruction of a non-diseased breast to achieve [symmetry](#) between the two breasts. Other examples of reconstructive breast surgery include [augmentation mammoplasty](#), reduction mammoplasty, and/or [mastopexy](#) of the non-diseased breast.

When Reconstructive Breast Surgery is covered

- ◆ Reconstructive breast surgery post mastectomy will be covered without regard to the time elapsed since a mastectomy. It may be performed at the time of the mastectomy or anytime post-operatively as long as the mastectomy was a medically necessary procedure, i.e., for breast cancer or other breast disease not responsive to conservative measures.
- ◆ [Augmentation mammoplasty](#), reduction [mammoplasty](#), and/or [mastopexy](#) of a non-diseased breast will be covered following medically necessary mastectomy for the purpose of achieving reasonable breast [symmetry](#).

When Reconstructive Breast Surgery is not covered

- ◆ When the member has a breast removed or reduced in size primarily for cosmetic reasons unrelated to mastectomy for breast cancer or breast disease. In this case, both the mastectomy and reconstruction would be excluded from coverage.

Policy Guidelines

Member's attending physician in consultation with the patient will determine the length of the hospital stay following a mastectomy if the member is hospitalized.

Billing and Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 11920, 11921, 11922, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19361, 19364, 19366, 19367, 19368, 19369, L8600, S2066, S2067, S2068.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all [specific](#) information needed to make a medical necessity determination is included.

Section II - Mastectomy for Gynecomastia

Gynecomastia refers to the benign enlargement of the male breast, either due to increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all three. Gynecomastia may be associated with any of the following:

- An underlying hormonal disorder
- A side effect of certain drugs
- Associated with obesity
- Related to specific age groups, (i.e., neonatal gynecomastia, adolescent gynecomastia, gynecomastia of aging)

Treatment of gynecomastia involves consideration of the underlying cause. For example, treatment of the underlying hormonal disorder, cessation of drug therapy or weight loss may all be effective therapies. Adolescent gynecomastia may resolve with aging. Surgical removal of the breast tissue (mastectomy) may be considered if conservative therapies are not effective.

When Mastectomy for Gynecomastia is covered

Mastectomy for the condition of gynecomastia is covered when **ALL** of the following conditions are met:

1. Male is over 18 years of age (Male gynecomastia is not uncommon in adolescent males, and generally resolves without treatment.) or male is over 17 years of age with significant breast tissue present for over two years **AND**
2. Excess breast tissue is glandular and not fatty tissue. (This is confirmed by clinical exam, mammogram and/or tissue pathology.) **AND**
3. Other causes of gynecomastia have been ruled out, including reversible drug treatments (When drugs can be discontinued). **AND**
4. Excessive breast development is not due to non-covered therapies or illicit drugs, e.g., anabolic steroids or marijuana **AND**
5. If gynecomastia is caused by obesity (BMI>30), it is documented to have failed to respond to conservative measures which must include participation in a clinically supervised, comprehensive weight loss and exercise program for at least 6 months, **AND**
6. The patient has documented and significant medical symptoms not resolved by more conservative treatments.

When Mastectomy for Gynecomastia is Not covered

Mastectomy for gynecomastia is not covered when the criteria listed above are not met.

Policy Guidelines

Mastectomy for Gynecomastia may require prior plan approval.

Billing and Coding/Physician Documentation Information for Gynecomastia

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 19300

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Section III - Reduction Mammoplasty

A reduction mammoplasty is performed to remove substantial breast tissue, including skin and underlying glandular tissue. It results in a significant reduction in the size of the breast, change in shape and an uplifting effect on the breast tissue. It differs from mastectomy where the entire breast is removed. When medically necessary, a reduction mammoplasty is used to relieve symptoms resulting from breast hypertrophy (an increase in the volume and weight of breast tissue in excess of the normal proportion) such as shoulder pain, back pain, and shoulder grooving. The surgery requires general anesthesia.

When Reduction Mammoplasty is covered

Reduction mammoplasty for symptomatic breast hypertrophy may be considered medically necessary and eligible for coverage when ALL of the following criteria are met (A, B, C, D, and E):

- A. The patient has significant symptoms that interfere with normal activities, including at least one of the following:
 1. symptomatic neck, back or shoulder pain not related to other causes (e.g., poor posture, acute strains, poor lifting techniques). Documentation of evaluation and treatment of neck, back or shoulder pain must be supplied.
 2. clinical, nonseasonal submammary intertrigo
- B. The patient's physical exam documents at least two of the following:
 1. significant shoulder grooving
 2. obvious breast hypertrophy (pictures are not necessary)
 3. suprasternal to nipple measurement of greater than 28 cm for women greater than or equal to 5' 2" tall, or 25 cm for women less than 5' 2" tall.
 4. physical exam is consistent with symptoms precipitating request for reduction mammoplasty
- C. Failure of conservative measures including:
 1. for back, neck, or shoulder pain, failure of 6 weeks of conservative treatment, including all of the following:
 - a. appropriate support bra and

Policy: Breast Surgeries

- b. NSAIDS (if not contraindicated) **and**
- c. Exercises and heat or cold application
2. for submammary **intertrigo**, 6 weeks of conservative treatment, **including all of the following:**
 - a. appropriate hygiene **and**
 - b. appropriate medical/pharmacologic treatment **and**
 - c. utilization of an appropriate support bra
- D. For patients with a **Body Mass Index (BMI)** greater than 27, a documented and legitimate medically based attempt to reduce and maintain weight. **This requirement relates specifically to patients with low back pain and/or intertrigo, where obesity is a documented risk factor.** In the absence of weight loss to a **BMI** less than or equal to 27, a legitimate attempt at weight loss includes **all of the following:**
 1. initial consultation with a physician or mid-level practitioner (Nurse Practitioner, Physician's Assistant) regarding weight loss **and**
 2. The weight loss attempt includes **all of the following:**
 - a. regular visits with a practitioner, nutritionist, or other recognized weight loss program over 3 months **and**
 - b. the weight loss program includes reasonable dietary modifications and appropriate aerobic exercise **and**
 - c. the record indicates that the patient has made reasonable attempts to comply with the weight loss program.
- E. The weight of breast tissue anticipated to be removed or removed must be greater than the threshold value for a given body surface area (BSA) in order to be considered medically necessary. (see Table I in "Policy Guidelines" section below).

Body surface area may be calculated by using the following formula:

$$BSA(m^2) = \sqrt{\frac{ht(in) \times wt(lb)}{3131}}$$

When Reduction Mammoplasty is Not covered

Reduction **mammoplasty** is not covered when the criteria listed above have not been met.

Policy Guidelines

Member's attending physician in consultation with the patient will determine length of the hospital stay if member is hospitalized.

Reduction **mammoplasty** may require prior plan approval.

Policy: Breast Surgeries

Table 1: Schnur Sliding Scale

Body surface area (in meters squared)	Threshold of breast tissue to be removed (in grams) from <u>each</u> breast
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662

Adapted from: Schnur, Paul L, et al., "Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?"

Policy: Breast Surgeries

Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7.

Billing and Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable code: 19318

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Section IV - Prophylactic Mastectomy

A prophylactic mastectomy is the removal of a breast, (usually the remaining non-cancerous breast), to prevent further development of cancer in those patients considered to be at high risk of developing or redeveloping breast cancer.

When Prophylactic Mastectomy is covered

Prophylactic Mastectomy is covered when two or more of the following criteria are met:

1. Breast biopsy indicates the patient is at high risk for breast cancer
2. Immediate family history of breast cancer (mother, sister, or daughter)
3. Breast Cancer (lobular or intraductal) in the contralateral breast
4. Severe fibrocystic disease that significantly complicates the reading of mammography studies. (Severe fibrocystic disease means that the patient has persistent pain and or breast discharge from fibrocystic disease not responsive to treatment with hormonal regulation and diet)
5. Maternal or paternal family history of breast cancer consistent with autosomal dominant inheritance (i.e., about half of the family members are affected.)

When Prophylactic Mastectomy is not covered

Prophylactic Mastectomy is not covered when the criteria listed above have not been met.

Policy Guidelines

Not applicable.

Policy: Breast Surgeries

Billing and Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 19301, 19302, 19303, 19304

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Section V - Insertion and Removal of Breast Implants

Breast implants are prostheses used for post-surgical mastectomy reconstruction. Breast implants are also used for breast enlargement for primarily cosmetic reasons. They may be internally placed or worn externally in the clothing. For internal use, the breast implant is placed into the breast area once the natural breast tissue has been removed. If a patient has adverse reaction to the implants, such as leakage or infection, the implant must be removed.

When Insertion and Removal of Breast Implants are covered

- Insertion is covered for post surgical mastectomy reconstruction.
- Removal is covered when it is medically necessary due to complications from an implantation for a covered indication (i.e., not primarily cosmetic).

When Insertion and Removal of Breast Implants are not covered

- Insertion of the implant is not covered for primarily cosmetic enhancement of the breast in the absence of mastectomy for breast cancer or other breast disease.
- Removal of the implant is not covered for asymptomatic patients desiring removal.
- Removal of the implant is not covered when the original implant surgery was primarily for cosmetic reasons or other non covered indications.

Policy Guidelines

- Insertion and Removal of Breast Implants may require prior plan approval.
- Screening for possible leakage of breast implants would initially involve mammography. If negative, the next diagnostic tool would be ultrasound or MRI of the breast.

Policy: Breast Surgeries

Billing and Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 19325, 19328, 19330, 19340, 19342, L8600

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Billing/Coding/Physician Documentation Information

Applicable codes: 11920, 11921, 11922, 19300, 19301, 19302, 19303, 19304, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19361, 19364, 19366, 19367, 19368, 19369, L8600, S2066, S2067, S2068.

Policy Key Words

Key Words: Mastectomy, Post Mastectomy, Breast Surgery, Augmentation Mammoplasty, Reduction Mammoplasty, Mastopexy, Nipple Complex, Areolar Complex, Nipple/Areolar Complex, Breast Reconstruction, Cancer, Gynecomastia, Reduction mammoplasty, mammoplasty, breast, reduction, Prophylactic Mastectomy, Breast Cancer, Insertion and Removal of Breast Implants

Medical Term Definitions

Areolar complex

circular area of darker color surrounding the nipple of the breast.

Asymptomatic

showing or causing no symptoms.

Augmentation

process of enlarging.

Body Mass Index

a measure of the body fat that is the ratio of the weight of the body in kilograms to the square of its height in meters. A body mass index that exceeds a value of 28 for a man or 27 for a woman is often used as an indication of obesity. Also referred to as BMI. $BMI = \text{weight (kilograms)} / [\text{height (meters)}]^2$

Intertrigo

inflammation of the skin in areas where skin surfaces rub such as the axillae, groin, between the toes, and under the breast, generally with itching, rash, burning, and occasional seeping lesions.

Policy: Breast Surgeries

Mammoplasty

plastic reconstruction of the breast which may be done to increase (augment) or decrease its size.

Mastopexy

Plastic surgery reconstruction of the breast to correct a loose hanging or pendulous breast.

Prosthesis

an artificial substitute for a missing body part, may be functional or cosmetic or both.

Symmetry of breasts

balanced and similar appearance from right to left breast.

Scientific Background and Reference Sources

Policy entitled: Reconstructive Breast Surgery Post Mastectomy

North Carolina Senate Bill 714, July 10, 1997

Federal Provisions in the Omnibus Appropriation Bill of 1998

Policy entitled: Mastectomy for Gynecomastia

National Association - 12/95

Policy entitled: Mammoplasty, Reduction

1995 Manual 60-1A, BCBSNC 1995 Prior Authorization Criteria

North Carolina Senate Bill 714, Provision of coverage for Reconstructive Breast Surgery resulting from mastectomy, July 10, 1997.

Policy entitled Subcutaneous and Prophylactic Mastectomy

Independent Review; Corporate and ADS Medical Directors

Physician Advisory Group, February 21, 1991

Medical Policy Advisory Group - 1/99

Policy entitled: Insertion and Removal of Silicone Breast Implants

Information - Food and Drug Administration, April 1992

Independent Review by Senior Director, Medical Affairs, 4/92

Physician Advisory Group, 8/92

Independent Review by Senior Director, Medical Affairs, 7/93

Consultant review, 2/98

Medical Policy Advisory Group 11/98

Policy entitled: Mastectomy, Length of Stay

North Carolina Senate Bill 273, Ratified August 19, 1997

New policy created entitled: Breast Surgeries

Specialty Matched Consultant Advisory Panel - 11/99

Medical Policy Advisory Group - 12/2/1999

Consultant review - 3/7/2000

Policy: Breast Surgeries

Medical Policy Advisory Group approved policy changes - 4/20/2000

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group - 12/2000

Specialty Matched Consultant Advisory Panel - 9/2002

BCBSA Medical Policy Reference Manual. 4/15/02, 7.01.13

BCBSA Medical Policy Reference Manual. 12/17/03, 7.01.21

Schnur, Paul L, et al., "Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?" *Annals of Plastic Surgery*. Sept 1991; 27 (3): 232-7

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.09, 7/17/03.

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.13, 10/9/03.

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.22, 7/17/03.

Specialty Matched Consultant Advisory Panel - 8/2004

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.22, 12/14/05

Policy Implementation/Update Information

Policy entitled: Reconstructive Breast Surgery Post Mastectomy

11/97 Original policy issued.

3/98 Revised: Removed statement under policy section "Reconstruction of the non-diseased breast should occur at the same time as reconstruction on the diseased breast.

11/98 Added statement, "Benefits are available for the physical complications related to all stages of the mastectomy, including treatment of associated lymphedema".

Policy entitled: Mastectomy for Gynecomastia

6/96 Original policy issued

7/97 Reaffirmed

Policy entitled: Reduction Mammoplasty

1/96 Original policy issued

5/96 Revised: Updated patient criteria

8/97 Revised: Change statement under Policy section from "Revision of remaining non-diseased breast as part of a post unilateral mastectomy reconstruction [is for cosmetic effect and is not covered]." to "is eligible for benefits when necessary to achieve symmetry between the two breasts," based on North Carolina Senate Bill 714.

Policy entitled: Prophylactic Mastectomy

5/91 Original policy issued

8/96 Reaffirmed

1/99 Reaffirmed: Medical Policy Advisory Group

Policy entitled: Insertion and Removal of Breast Implants

5/92 Original policy issued

Policy: Breast Surgeries

- 7/93 Revised: Policy revised and effective date reinstated 7/28/93
- 8/96 Reaffirmed
- 9/98 Reviewed: Added information related to MRI not indicated to detect breast cancer in patients with implants and appropriate diagnostic tools to detect implant leakage.

Policy entitled: Mastectomy, Length of Stay

- 1/98 Original Policy issued

New policy created entitled: Breast Surgery

- 5/99 Combined Reconstructive breast surgery post mastectomy, Mastectomy for gynecomastia, Reduction mammoplasty, Prophylactic Mastectomy, and Insertion and Removal of Breast Implants. Mastectomy Length of Stay policy incorporated throughout the policy. No separate section dedicated to this policy. Reformatted and added medical term definitions.
- 12/99 Approved, Medical Policy Advisory Group
- 2/00 Typographical errors corrected. System coding changes.
- 3/00 Consultant review. Medical criteria modifications include: 1.) Mastectomy for Gynecomastia - phrase added "when drugs can be discontinued"; 2.) Reduction Mammoplasty - added suprasternal to nipple measurement for women equal to or over 5' 2" tall, and for under 5' 2" tall; added criteria detailing weight loss attempt under when it is covered.
- 4/00 Added Medical Policy Advisory Group reference to the Scientific Background and Reference Source section of the policy.
- 10/00 System coding changes.
- 12/00 Specialty Matched Consultant Advisory panel review. Changes to criteria for gynecomastia stating, "...male is over 17 years of age with significant breast tissue present for over two years." Also added information stating that glandular breast tissue can be confirmed by clinical exam, mammogram and/or tissue pathology. Medical Policy Advisory Group review. No further changes to policy.
- 04/01 Changes in formatting. Typographical errors corrected.
- 5/01 Revised. Under what is covered for Prophylactic Mastectomies, the term "normal" was changed to "hormonal". Commas removed.
- 10/01 Coding format changes.
- 6/02 Policy reformatted for clarity. Definition of Intertrigo changed from "irritation" to "inflammation". Definition added for Body Mass Index (BMI). Removed the statement, "inability to sleep in a reclined position due to shortness of breath." from the When Reduction Mammoplasty is covered section of the policy. Added code L8600 to the policy.
- 10/02 Specialty Matched Consultant Advisory Panel review. No change in policy. System coding changes.
- 11/02 New Source added. Revised "When Mastectomy for Gynecomastia is Covered" section revised to be consistent with certificate language.
- 1/04 Benefits Application and Billing/Coding sections updated for consistency.
- 2/04 Section III - Reduction Mammoplasty - "When covered" - D. second sentence now reads "This requirement relates specifically to patients with low back pain and/or intertrigo, where obesity is a documented risk factor." Typos corrected.
- 4/22/04 Changes made for Section III-Reduction Mammoplasty: "When covered", E. criteria revised "The weight of breast tissue to be removed or removed must be greater than the threshold value for a

Policy: Breast Surgeries

given BSA in order to be considered medically necessary." Also added body surface area formula. Under "Policy Guidelines", added Table 1: Schnur Sliding Scale. Reference sources added. Notification given 4/22/04. Effective date 7/1/04.

- 10/28/04 Specialty Matched Consultant Advisory Panel review - 8/27/04. Under Benefits Application; added "Breast surgeries included in this policy may require prior plan approval." Under Section II - Mastectomy for Gynecomastia; Expanded "Description" section, under "When it is Covered" pulled obesity out of #3 and added as a separate entity with guidelines - "If gynecomastia is caused by obesity (BMI>30), it is documented to have failed to respond to conservative measures which must include participation in a clinically supervised, comprehensive weight loss and exercise program for at least 6 months, **AND**....." Under Section III - Reduction Mammoplasty; "Policy Guidelines", Table I: Schnur Sliding Scale, added "from each breast" to the end of "Threshold of breast tissue to be removed (in grams). Under Section V - Insertion and Removal of Breast Implants; removed "MRI has not been established as a screening modality for breast cancer even in the presence of breast implants." based on MRI of The Breast policy #RAD5105. Reference sources added. Notification given 10/28/04. Effective date 1/6/05.
- 1/6/05 Removed CPT codes 19160, 19162, 19180, 19182, 19200, 19220, 19240, L8030 and L8039 from Section I, Reconstructive Breast Surgery - After Mastectomy, Billing/Coding section. Section I is for reconstruction, not the actual mastectomy so the mastectomy codes were removed. Codes 19328 and 19330 added to section I. Codes L8030 and L8039 are for the type of prosthesis that can be worn in a bra, not implanted (removed these two codes from Section I and V). Appropriate additions and removals indicated in final Billing/Coding section that includes all codes in each section.
- 2/2/06 Added 2006 HCPCS code S2068 to Section I, Reconstructive Breast Surgery, Billing/Coding section and in the final Billing/Coding section that includes all codes in the policy.
- 12/11/06 Policy status changed to "Active policy, no longer scheduled for routine literature review."
- 1/3/07 CPT codes 19300, 19301, 19302, 19303 and 19304 effective January 1, 2007 added to Billing/Coding section. Removed deleted CPT codes 19140, 19160, 19162, 19180 and 19182. (pmo)
- 7/2/07 HCPCS codes S2066 and S2067, effective July 1, 2007 added to appropriate Billing/Coding sections. (pmo)
- 6/22/10 Policy Number(s) removed (amw)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.