Sentara Health Plans

Medicaid

Mastectomy Garments

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Effective Date	06/2012
Next Review Date	09/2024
Coverage Policy	DME 240
Version	4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Mastectomy Garments.

Description & Definitions:

Mastectomy garments are designed for patients who do not elect to have breast reconstruction after a mastectomy to provide symmetry to their body with an external breast prosthetic. Therapeutic ambulatory orthotic systems (TAOS) – Is an orthotic device worn on the outside of clothes that supports the body to assist with hands-free ambulation.

Mastectomy Bras or camisole: either 4 prosthetic Bras or 4 prosthetic camisoles initially or combination of both to total 4 garments, then 1 prosthetic garment every 3 months thereafter.

Mastectomy Prosthetic / Form: 1 per side per year (or with bilateral mastectomy--one form for each side per year).

Criteria:

Mastectomy garments are considered medically necessary for **all** of the following:

- Individual has had a mastectomy (bilateral or unilateral)

The following Mastectomy Garments do not meet the definition of medical necessity, to include but not limited to:

- Custom breast prosthesis

Coding:

Medically necessary with criteria:

Coding	Description
L8000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type

L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type
L8010	Breast prosthesis, mastectomy sleeve
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy
L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8031	Breast prosthesis, silicone or equal, with integral adhesive
L8032	Nipple prosthesis, prefabricated, reusable, any type, each
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8039	Breast prosthesis, not otherwise specified

Considered Not Medically Necessary:

Coding	Description
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each

Document History:

Revised Dates:

- 2019: November
- 2015: January, September, December
- 2014: January, October
- 2013: January, December

Reviewed Dates:

- 2023: September
- 2022: September
- 2021: December
- 2020: December
- 2019: October
- 2018: August
- 2017: November
- 2016: January

Effective Date:

- June 2012

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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(2023). Retrieved Aug 10, 2023, from UpToDate: https://www.uptodate.com/contents/search?search=External%20Breast%20Prosthesis&sp=0&searchType=PLAIN_TEXT&source=USER_INPUT&searchControl=TOP_PULLDOWN&searchOffset=1&autoComplete=false&language=&max=0&index=&autoCompleteTerm=&rawSentence=

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

All medically necessary medical equipment and supplies under the Virginia Administrative Code (12VAC30-50-165) may be covered only if they are necessary to carry out a treatment prescribed by a practitioner. Only supplies, equipment, and appliances that are determined medically necessary may be covered for reimbursement by DMAS. (12VAC30-50-165) The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS, or its contractor. Medically necessary DME and supplies shall be:

- Ordered by the practitioner on the CMN/DMAS-352;
- A reasonable and medically necessary part of the individual's treatment plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual; • Not furnished for the safety or restraint of the individual, or solely for the convenience of the family, attending practitioner, or other practitioner or supplier;

- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational);
- Furnished at a safe, effective, and cost-effective level; and
- Suitable for use, and consistent with 42 CFR 440.70(b)(3), that treats a diagnosed condition or assists the individual with functional limitations.

Keywords:

SHP Mastectomy Garments, SHP Durable Medical Equipment 240, Mastectomy, bra, camisole