

if DYS46 is 30 and DYS29 is 11, one is probably a member of haplogroup R1a.



**HEALTHHELP**<sup>®</sup>

A WNS COMPANY

UPDATED 02.01.2018

# CLINICAL GUIDELINES

DYS426 is 11 and DYS388 is 1  
nodal haplotype for G shown above

## Oncology Surgery

# Overview Statement

---

The purpose of this Clinical Guideline is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to improve patient outcomes. This Clinical Guideline neither preempts clinical judgment of trained professionals nor advises anyone on how to practice medicine. The healthcare professionals are responsible for all clinical decisions based on their assessment. This Clinical Guideline is not an authorization, certification, explanation of benefits, or a guarantee of payment, nor does it substitute for, or constitute, medical advice.

Federal and State law, as well as member benefit contract language, including definitions and specific contract provisions/exclusions, take precedence over Clinical Guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

Medical information is constantly evolving, and HealthHelp reserves the right to review and update this Clinical Guideline periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from HealthHelp. All trademarks, product names, logos and brand names are the property of their respective owners and used for purpose of information/illustration only.

# Table of Contents

---

Overview Statement.....	2
Table of Contents .....	3
Excisional Biopsy: Breast .....	4
Lumpectomy: Breast.....	7
Simple Mastectomy.....	10
Thoracoscopy: Lung Wedge Resection.....	12

# Excisional Biopsy: Breast

---

The use of Excisional Biopsy of the breast may be appropriate and supported by evidence to improve outcomes for patients who are being evaluated for primary breast cancer when the patient's medical record demonstrates the following:

1. Physician is not planning to perform a lumpectomy in conjunction with an excisional biopsy. The patient has had prior breast imaging performed via MRI/ultrasound of the breast or mammogram; and **ANY** of the following:
  - Patient does not have **ANY** of the following:
    - Breast abnormality that fluctuates with menstrual cycle;
    - Breast abnormality which is BI-RADS 1-3;
    - A cystic breast mass;
    - Suspected fibroadenoma of the breast;
    - Vascular malformation of the breast.
  - Patient has had a previous incisional biopsy with **ANY** of the following:
    - Discordance between imaging characteristics and core biopsy histology;
    - Core needle biopsy which was either non-diagnostic or highly suspicious of cancer;
    - Non-diagnostic specimen from core biopsy due to insufficient material, lack of calcifications or hemorrhage;
    - Suspicious interval changes are present in a lesion which was previously diagnosed benign by core biopsy;
    - Atypical hyperplasia (ductal or lobular) or lobular carcinoma in-situ (LCIS) present on core biopsy;
    - Papillary and/or sclerosing lesion on core biopsy;
    - Fibroepithelial lesion (fibroadenoma vs benign phyllodes tumor) on core biopsy.

- Patient has not had a previous biopsy with **ANY** of the following:
  - Patient has a cystic breast mass that does not resolve after one or more attempts at drainage;
  - Lesion is not anatomically suitable for core biopsy, i.e. lesion is too far anterior or posterior or is too close to a breast implant;
  - Patient is anatomically unsuitable for biopsy, i.e. breast tissue is too thin or patient is too large for the biopsy table;
  - Suspicious nipple discharge is present with normal breast imaging.

## REFERENCES

- Gutwein LG, Ang DN, Liu H, et al. Utilization of minimally invasive breast biopsy for the evaluation of suspicious breast lesions. *Am J Surg* 2011; 202:127.
- Melotti MK, Berg WA. Core needle breast biopsy in patients undergoing anticoagulation therapy: preliminary results. *AJR Am J Roentgenol* 2000; 174:245.
- Somerville P, Seifert PJ, Destounis SV, et al. Anticoagulation and bleeding risk after core needle biopsy. *AJR Am J Roentgenol* 2008; 191:1194.
- Harris L, Fritsche H, Mennel R, et al. American Society of Clinical Oncology 2007 update of recommendations for the use of tumor markers in breast cancer. *J Clin Oncol* 2007; 25:5287.
- Elmore JG, Longton GM, Carney PA, et al. Diagnostic concordance among pathologists interpreting breast biopsy specimens. *JAMA* 2015; 313:1122.
- National Comprehensive Cancer Network (NCCN). NCCN Clinical practice guidelines in oncology. [http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp) (Accessed on February 27, 2016).
- Mannello F, Tonti GA, Papa S. Human gross cyst breast disease and cystic fluid: bio-molecular, morphological, and clinical studies. *Breast Cancer Res Treat* 2006; 97:115.
- [Louie L, Velez N, Earnest D, Staren ED. Management of nonpalpable ultrasound-indeterminate breast lesions. \*Surgery\* 2003; 134:667.](#)
- Gordon PB. Image-directed fine needle aspiration biopsy in nonpalpable breast lesions. *Clin Lab Med* 2005; 25:655.
- Morrow M. The evaluation of common breast problems. *Am Fam Physician* 2000; 61:2371.
- Dixon JM, McDonald C, Elton RA, Miller WR. Risk of breast cancer in women with palpable breast cysts: a prospective study. Edinburgh Breast Group. *Lancet* 1999; 353:1742.
- Parish DC, Ghilchik MW, Day JM, et al. Cytokines in human breast cyst fluid. *J Steroid Biochem Mol Biol* 2007; 104:241.
- Tsung JS, Wang TY, Wang SM, Yang PS. Cytological and biochemical studies of breast cyst fluid. *Breast* 2005; 14:37.
- Pisano ED, Fajardo LL, Caudry DJ, et al. Fine-needle aspiration biopsy of nonpalpable breast lesions in a multicenter clinical trial: results from the radiologic diagnostic oncology group V. *Radiology* 2001; 219:785.
- Scott S, Morrow M. Breast cancer. Making the diagnosis. *Surg Clin North Am* 1999; 79:991.

# Lumpectomy: Breast

---

The use of Lumpectomy of the breast may be appropriate and supported by evidence to improve outcomes for patients who are being treated for primary breast cancer when the patient's medical record demonstrates the following:

1. Physician is not planning to perform an excisional biopsy in conjunction with the lumpectomy; and **EITHER** of the following:
  - Lumpectomy is being done for consideration of recurrence of previously known breast cancer in a patient who did not undergo neoadjuvant chemotherapy and who has had a core biopsy performed; and **EITHER** of the following:
    - Request is for a repeat lumpectomy; and **EITHER** of the following:
      - Repeat lumpectomy to the same site as the previous lumpectomy being performed for margin clearance;
      - Repeat lumpectomy to a different site than the previous lumpectomy.
    - Request is for an initial lumpectomy; and **BOTH** of the following:
      - Core biopsy was positive for malignancy;
      - Sentinel node biopsy is planned.
  - Lumpectomy is for initial diagnosis of breast cancer in a patient who has had a core biopsy performed, but has not undergone neoadjuvant chemotherapy; and **EITHER** of the following:
    - Request is for a repeat lumpectomy; and **EITHER** of the following:
      - Repeat lumpectomy to the same site as the previous lumpectomy being performed for margin clearance;
      - Repeat lumpectomy to a different site than the previous lumpectomy.
    - Request is for an initial lumpectomy; and **BOTH** of the following:

- Core biopsy was positive for malignancy;
- Sentinel node biopsy is planned.

## REFERENCES

- Fisher B, Anderson S, Redmond CK, et al. Reanalysis and results after 12 years of follow-up in a randomized clinical trial comparing total mastectomy with lumpectomy with or without irradiation in the treatment of breast cancer. *N Engl J Med* 1995; 333:1456.
- Fisher B, Anderson S, Bryant J, et al. Twenty-year follow-up of a randomized trial comparing total mastectomy, lumpectomy, and lumpectomy plus irradiation for the treatment of invasive breast cancer. *N Engl J Med* 2002; 347:1233.
- Veronesi U, Salvadori B, Luini A, et al. Breast conservation is a safe method in patients with small cancer of the breast. Long-term results of three randomised trials on 1,973 patients. *Eur J Cancer* 1995; 31A:1574.
- Veronesi U, Cascinelli N, Mariani L, et al. Twenty-year follow-up of a randomized study comparing breast-conserving surgery with radical mastectomy for early breast cancer. *N Engl J Med* 2002; 347:1227.
- van Dongen JA, Voogd AC, Fentiman IS, et al. Long-term results of a randomized trial comparing breast-conserving therapy with mastectomy: European Organization for Research and Treatment of Cancer 10801 trial. *J Natl Cancer Inst* 2000; 92:1143.
- Jacobson JA, Danforth DN, Cowan KH, et al. Ten-year results of a comparison of conservation with mastectomy in the treatment of stage I and II breast cancer. *N Engl J Med* 1995; 332:907.
- Poggi MM, Danforth DN, Sciuto LC, et al. Eighteen-year results in the treatment of early breast carcinoma with mastectomy versus breast conservation therapy: the National Cancer Institute Randomized Trial. *Cancer* 2003; 98:697.
- Arriagada R, Lê MG, Rochard F, Contesso G. Conservative treatment versus mastectomy in early breast cancer: patterns of failure with 15 years of follow-up data. Institut Gustave-Roussy Breast Cancer Group. *J Clin Oncol* 1996; 14:1558.
- Blichert-Toft M, Rose C, Andersen JA, et al. Danish randomized trial comparing breast conservation therapy with mastectomy: six years of life-table analysis. Danish Breast Cancer Cooperative Group. *J Natl Cancer Inst Monogr* 1992; :19.
- Clarke M, Collins R, Darby S, et al. Effects of radiotherapy and of differences in the extent of surgery for early breast cancer on local recurrence and 15-year survival: an overview of the randomised trials. *Lancet* 2005; 366:2087.

# Simple Mastectomy

---

Simple Mastectomy may be medically appropriate and supported by evidence to improve patient outcomes for the following indications.

1. Curative Mastectomy to treat current diagnosis of primary breast cancer.
2. Prophylactic Mastectomy to decrease risk of bilateral breast cancer in patients who have tested positive for the BRCA-1 or BRCA-2 gene but who have not been diagnosed with breast cancer.
3. Prophylactic Mastectomy to decrease risk of contralateral breast cancer in patients may be reasonable and appropriate when the patient's medical record demonstrates the following:
  - Diagnosis of breast cancer; and **ANY** of the following:
    - Tested positive for either the BRCA-1 or BRCA-2 gene;
    - Patient has a first degree relative with breast cancer;
    - Patient has a history of radiation therapy to the chest wall.

## REFERENCES

- European Society for Radiotherapy and Oncology (ESTRO). "Is breast conserving therapy or mastectomy better for early breast cancer? New study sheds light on best choices for younger and older women with early breast cancer." ScienceDaily. ScienceDaily, 30 April 2016.
- JAMA Surg. 2015 Jan;150(1):9-16. doi: 10.1001/jamasurg.2014.2895.
- JAMA Surg. 2014 Jun;149(6):582-9. doi: 10.1001/jamasurg.2013.5689.
- Moran et al. 2014. Society of Surgical Oncology-American Society for Radiation Oncology consensus guideline on margins for breast-conserving surgery with whole-breast irradiation in stages I and II invasive breast cancer. *Int J Radiat Oncol Biol Phys.* 88(3):553-64.
- Merrill et al. 2016. Should New "No Ink On Tumor" Lumpectomy Margin Guidelines be Applied to Ductal Carcinoma In Situ (DCIS)? A Retrospective Review Using Shaved Cavity Margins. *Ann Surg Oncol.* 2016 May 20. [Epub ahead of print]
- Grobmyer et al. 2013. Optimizing clinical management of surgical margins in breast-conserving therapy for breast cancer. *Am Soc Clin Oncol Educ Book.* 66-71.
- Memorial Slone Kettering Cancer Center. 2014. Breast Surgery Guidelines Take Aim at Unnecessary Operations
- BreastCancer.org. New Guidelines Say Lumpectomy Margins Can Be Small as Long as Tumor Has No Ink on It
- Gøtzsche PC, Nielsen M. 2006. Screening for breast cancer with mammography. *Cochrane Database Syst Rev.* (4):CD001877.
- Brewer NT, et al. 2007. Systematic Review: The Long-Term Effects of False-Positive Mammograms *Ann Intern Med.* 146:502-510.
- Elmore JG, et al. 2002. Screening mammograms by community radiologists: variability in false-positive rates. *J Natl Cancer Inst.* 94(18):1373-80.
- Morris et al. 2015. Implications of Overdiagnosis: Impact on Screening Mammography Practices. *Popul Health Manag. Suppl* 1:S3-11.
- Cancermonthly.com. Study Concludes That Mammography Can Lead to Unnecessary Lumpectomies, Mastectomies and Radiation Therapy
- Morrow et al. 2001. Factors predicting the use of breast-conserving therapy in stage I and II breast carcinoma. *J Clin Oncol.* (8):2254-62.
- Whelan TJ et al. 2010. Long-term results of hypofractionated radiation therapy for breast cancer. *N Engl J Med.* 362:513-20.
- Bentzen et al. 2008. The UK Standardisation of Breast Radiotherapy (START) Trial B of radiotherapy hypofractionation for treatment of early breast cancer: a randomised trial. *Lancet.* 371(9618): 1098-107
- Smith BD et al. 2011. Fractionation for whole breast irradiation: an American Society for Radiation Oncology (ASTRO) evidence-based guideline. *Int J Radiat Oncol Biol Phys.* 81(1):59-68.

# Thoracoscopy: Lung Wedge Resection

---

Performing a Thoracoscopy: Lung Wedge Resection may be medically appropriate and supported by evidence to improve patient outcomes for the purposes of diagnostic biopsy of lung infiltrates, nodules or in cases where an initial therapeutic wedge resection is required for the following indications.

1. Thoracoscopy for Stage I or Stage II lung cancer may be reasonable and appropriate when the patient's medical record demonstrates **ALL** of the following:
  - Patient has had a CT of the Chest and FDG-PET scans to evaluation all primary pulmonary lesions;
  - Primary lesion is located in the outer 1/3 of the affected lung field; and **BOTH** of the following:
    - Primary lesion measuring less than or equal to three (3) centimeters (cm) in diameter;
    - Primary lesion type is either non-solid or greater than 50% in ground glass appearance on CT of the Chest.
  - There is histological confirmation of primary lung cancer via biopsy; and **ANY** of the following:
    - Patient has a cardiovascular co-morbidity or high pre-operative cardiac risk; and **BOTH** of the following:
      - Patient has had a cardiopulmonary exercise test to assess surgical risk resulting in either low risk (VO<sub>2</sub>max>20ml/kg/min or >75%) or moderate risk (VO<sub>2</sub>max 10-20 ml/kg/min or 35-75%);
      - Complete resection of the tumor in its entirety will be achieved with the primary malignancy controlled.

- Patient has no cardiovascular co-morbidity, sufficient pulmonary reserve as determined by pulmonary function testing (PFT) and complete resection of the tumor in its entirety will be achieved with the primary malignancy controlled.
  - Patient has had PFT with predicted postoperative forced expiratory volume (PPO FEV1) and diffusing capacity for carbon monoxide (DLCO) calculations performed; and **BOTH** of the following:
    - Patient has had a cardiopulmonary exercise test to assess surgical risk resulting in either low risk (VO<sub>2</sub>max >20ml/kg/min or >75%) or moderate risk (VO<sub>2</sub>max 10-20 ml/kg/min or 35-75%);
    - Complete resection of the tumor in its entirety will be achieved with the primary malignancy controlled.
2. Thoracoscopy for pulmonary metastasis (metastasectomy) may be reasonable and appropriate when the patient's medical record demonstrates **ALL** of the following:
- Patient has had a CT of the Chest and FDG-PET scans to evaluation all primary pulmonary lesions;
  - Patient has one (1) to seven (7) pulmonary metastatic lesions found on imaging;
  - There is histological confirmation of pulmonary metastasis via biopsy; and **ANY** of the following:
    - Patient has a cardiovascular co-morbidity or high pre-operative cardiac risk; and **BOTH** of the following:
      - Patient has had a cardiopulmonary exercise test to assess surgical risk resulting in either low risk (VO<sub>2</sub>max >20ml/kg/min or >75%) or moderate risk (VO<sub>2</sub>max 10-20 ml/kg/min or 35-75%);
      - Complete resection of the tumor in its entirety will be achieved with the primary malignancy controlled.
    - Patient has no cardiovascular co-morbidity, sufficient pulmonary reserve as determined by pulmonary function testing (PFT) and

complete resection of the tumor in its entirety will be achieved with the primary malignancy controlled.

- Patient has had PFT with predicted postoperative forced expiratory volume (PPO FEV1) and diffusing capacity for carbon monoxide (DLCO) calculations performed; and **BOTH** of the following:
  - Patient has had a cardiopulmonary exercise test to assess surgical risk resulting in either low risk (VO<sub>2</sub>max > 20 ml/kg/min or > 75%) or moderate risk (VO<sub>2</sub>max 10-20 ml/kg/min or 35-75%);
  - Complete resection of the tumor in its entirety will be achieved with the primary malignancy controlled.

## REFERENCES

- J Thorac Cardiovasc Surg. 2017 May 20. pii: S0022-5223(17)31049-8. doi: 10.1016/j.jtcvs.2017.04.071.
- Wang Y. Video-assisted thoracoscopic surgery for non-small-cell-lung-cancer is beneficial to elderly patients. *Int J LCin Exp Med*. 2015
- Cafarotti S, Cusumano G, Giuliani M, et al. Extra-anatomical VATS lung resection: the outpatient experience with the aid of a digital chest drain device. *Eur Rev Med Pharmacol Sci*. 2015 Oct. 19(20):3850-4
- Sakuma T, Sugita M, Sagawa M, Ishigaki M, Toga H. Video-assisted thoracoscopic wedge resection for pulmonary sequestration. *Ann Thorac Surg*. 2004 Nov. 78(5):1844-5.
- Hazelrigg SR, Nunchuck SK, Landreneau RJ, et al. Cost analysis for thoracoscopy: thoracoscopic wedge resection. *Ann Thorac Surg*. 1993 Sep. 56(3):633-5.
- Nakajima J, Takamoto S, Kohno T, Ohtsuka T. Costs of videothoracoscopic surgery versus open resection for patients with of lung carcinoma. *Cancer*. 2000 Dec 1. 89(11 Suppl):2497-501.
- Ginsberg RJ, Rubinstein LV. Randomized trial of lobectomy versus limited resection for T1 N0 non-small cell lung cancer. Lung Cancer Study Group. *Ann Thorac Surg*. 1995 Sep. 60(3):615-22; discussion 622-3.
- Russo L, Wiechmann RJ, Magovern JA, et al. Early chest tube removal after video-assisted thoracoscopic wedge resection of the lung. *Ann Thorac Surg*. 1998 Nov. 66(5):1751-4.
- Refai M, Brunelli A, Salati M, Xiume F, Pompili C, Sabbatini A. The impact of chest tube removal on pain and pulmonary function after pulmonary resection. *Eur J Cardiothorac Surg*. 2012 Apr. 41(4):820-2; discussion 823. [Full Text].
- Kaseda S, Aoki T, Hangai N, Shimizu K. Better pulmonary function and prognosis with video-assisted thoracic surgery than with thoracotomy. *Ann Thorac Surg*. 2000 Nov. 70(5):1644-6.
- Colice GL, Shafazand S, Griffin JP, Keenan R, Bolliger CT, American College of Chest Physicians. Physiologic evaluation of the patient with lung cancer being considered for resectional surgery: ACCP evidenced-based clinical practice guidelines (2nd edition). *Chest*. 2007 Sep. 132(3 Suppl):161S-77S.

## APPENDIX A: CPT AND HCPCS CODES ASSOCIATED WITH THIS POLICY

Any CPT or HCPCS codes that have been associated with this HealthHelp Clinical Guideline are for informational use only. The inclusion of a code in this guideline does not guarantee coverage or reimbursement by the individual health plan.

<b>ONCOLOGY SURGERY</b>	
<b>Excisional Biopsy - Breast</b>	<b>CODES:</b>
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions	19120
Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	19125
<b>Lumpectomy - Breast</b>	<b>CODES:</b>
Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	19301
Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	19302
<b>Mastectomy - Breast</b>	<b>CODES:</b>
Mastectomy for gynecomastia	19300
Mastectomy, simple, complete	19303
Mastectomy, subcutaneous	19304
<b>Biopsy / Wedge Resection - Lung</b>	<b>CODES:</b>
Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	32096
Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	32097
Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial	32505
Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	32607
Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	32608
Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral	32666