MEDICAL POLICY STATEMENT
GEORGIA MARKETPLACE

Policy Name	Policy Number	Date Effective
Screening and Diagnostic Mammography	MM-0882	08/01/2020-03/31/2021

Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CareSource and itsaffiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statementsprepared by CareSource and itsaffiliatesdo not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under thispolicy.

Table of Contents

A. Subject

Screening and Diagnostic Mammography

B. Background

Breast cancer is the most frequent type of non-skin cancer among women and is frequently diagnosed in women ages 55-64. The United States Preventative Services Task Force has found evidence that mammogram screening reduces breast cancer mortality in women ages 40-74.

C. Definitions

- **Mammogram** – Any low-dose radiologic screening procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician's interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology. This includes conventional, digital, and 3D.
- **Screening mammogram** – Performed on a female without any clinical signs or symptoms.
- **Diagnostic mammogram** – Performed on a person with clinical signs or symptoms; or an abnormal screening mammography.
- **Female at high risk** – Female who has
  - A personal history of breast cancer;
  - A personal history of biopsy proven benign breast disease;
  - A grandmother ,mother, sister, or daughter has had breast cancer; or
  - Not given birth prior to age 30.

NOTE: Members who are biologically females but identity as males are considered females for the purposes of this policy.

D. Policy

I. Prior Authorization
   A. A prior authorization is not required for screening mammography.
   B. A prior authorization is required for diagnostic outpatient mammograms.

II. Facility must meet accreditation standards established by the American College of Radiology or equivalent standards established by the state of Georgia.

III. Mammograms
   A. Screening mammograms
      1. Are covered for women with at least the following frequency:
         a. A baseline between ages of 35 and 39;
         b. Once every 2 years between ages 40-49; and

c. Once every year for 50 years and older.

01. High risk screening – for members who are deemed to be high risk it may be appropriate to start screening at an earlier age with mammography. CareSource may request medical documentation to support medical necessity for testing in women younger than 35 or more frequent testing than stated in D. III. A. 1. a. b. and c. Additional modalities of testing (such as MRI) will require a prior authorization and medical necessity review.

NOTE: CareSource may request medical documentation to support medical necessity for any additional procedures.

B. Diagnostic mammograms are covered for men and women who show clinical sign and symptoms of breast cancer (i.e., an abnormal screening mammogram, a breast mass/lump, etc.) or who are at high risk for developing breast cancer, when ordered by a practitioner based on medical necessity.

VI. CareSource will use MCG Health guidelines for medical necessity.

E. Conditions of Coverage

F. Related Polices/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	04/29/2020	New policy
Date Revised		
Date Effective	08/01/2020	
Date Archived	03/31/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. MCG Health: Ambulatory Care Guidelines, 23rd Ed., 2019.
2. Official Code of Georgia Annotated. (2019) *33-29-3.2 Coverage for mammograms, Pap smears, and prostate specific antigen tests*. Retrieved April 7, 2020 from www.ga.elaws.us.com
3. American Cancer Society. (2020, March 5). *Mammogram Basics*. Retrieved April 14, 2020 from www.cancer.org