



MEDICAL POLICY STATEMENT GEORGIA MEDICAID

Policy name	Policy Number	Effective Date	
Breast Reconstruction Surgery	MM-0732	09/01/2020-06/30/2021	
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) 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 Statements prepared by CSMG Co. and its affiliates (including CareSource) do 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.

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A. SUBJECT

Breast Reconstruction Surgery

B. BACKGROUND

Breast reconstruction procedures may be done to improve symmetry, reconstruct the nipple, or manage contour abnormalities. It may be performed following a mastectomy, breast conserving surgery, or other breast abnormality. Timing of the reconstruction will vary from immediate (during the mastectomy), delayed (weeks or years), or can be completed in several stages.

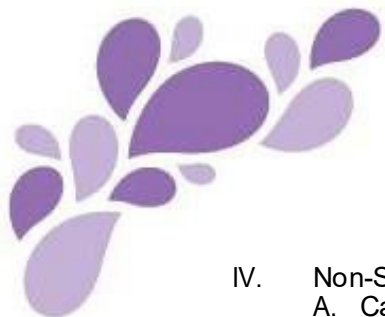
Refer to MCG for total mastectomy.

C. DEFINITIONS

- **Mastectomy:** Surgical removal of one or both breasts.
- **Breast conserving surgery (lumpectomy, partial mastectomy):** Surgical removal of tumor and small amount of surrounding tissue
- **Contralateral breast:** Unaffected/nonsurgical breast
- **Cosmetic procedures:** Procedures completed to improve appearance and self-esteem, and are to reshape normal structures of the body.

D. POLICY

- I. Prior authorization is required.
- II. Breast reconstruction is not gender-specific.
- III. Surgical Options
 - A. CareSource considers breast reconstruction medically necessary
 1. Following mastectomy or breast conserving surgery of the affected breast
 2. On the contralateral breast to produce a symmetrical appearance
 - B. Breast reconstruction procedures are considered medically necessary to improve breast function after conservatory therapy and when related to significant abnormalities/deformities as a result of any of the following:
 1. Malignant breast disease
 2. Congenital deformities that affect the member's physical and psychological being
 3. Severe fibrocystic breast disease that limits the member's function
 4. Unintentional trauma or injuries
 5. Unintentional complications after breast surgery for non-malignant conditions. This would include pain, irritation, bleeding, or discharge as well as a complication causing difficulty with lactation.
 6. Risk reduction mastectomy
 - C. CareSource considers physical complications including lymphedema following breast reconstruction as medically necessary.
 - D. Surgical Exclusions
 1. CareSource **DOES NOT** cover **ANY** breast reconstruction procedures that are considered experimental, investigational or unproven for this indication
 2. CareSource **DOES NOT** cover
 - a. Procedures that are considered cosmetic in nature including natural changes due to aging and weight loss/gain OR
 - b. Lipectomy for donor site symmetry OR
 - c. Suction lipectomy or ultrasonically-assisted suction lipectomy (liposuction) for correction of surgically-induced donor site asymmetry (e.g., trunk or extremity) that results from one or more flap breast reconstruction procedures.



- IV. Non-Surgical Alternatives
 - A. CareSource covers external breast prostheses and mastectomy bras following mastectomy or breast conserving surgery.
 - B. CareSource **DOES NOT** cover an external breast prosthesis or mastectomy bra for any other indication because it is considered not medically necessary.

E. CONDITIONS OF COVERAGE

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

DATE		ACTION
Date Issued	04/01/2020	
Date Revised		Updated Criteria
Date Effective	09/01/2020	
Date Archived	06/30/2021	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. Breast reconstruction in women with breast cancer; The Center for Consumer Information & Insurance Oversight; Women's Health and Cancer Rights Act (WHCRA): http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html
2. Nahabedian, M. Overview of Breast Reconstruction. Last updated July 2018. UpToDate Inc. Waltham, MA.
3. Sable, M. Breast conserving Therapy. Last updated September 2018. UpToDate Inc. Waltham, MA
4. Mehrara, B. Breast cancer-associated lymphedema. Last updated August 2018. UpToDate Inc. Waltham, MA
5. National Determination Coverage 140.2 Breast Reconstruction Following Mastectomy Retrieved on 3/22/2019 from <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?ncdid=64>
6. Milliman Care Guidelines (MCG) 23rd Edition (2019)

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

Independent medical review - 4/2019

GA-MED-P-105010

Date Issued 04/01/2020

DCH Approved 06/09/2020