MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Breast Reconstruction Surgery-GA MCD-MM-0732	08/01/2022-03/31/2023
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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. 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 this policy.

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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

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

D. Policy

I. CareSource considers breast reconstruction surgery medically necessary when the criteria in this policy are met.

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 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 the following:
   a. Procedures that are considered cosmetic in nature including natural changes due to aging and weight loss/gain,
   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

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/01/2020	
Date Revised	02/17/2021 03/16/2022	Updated Criteria No changes to content. Updated reference dates. Approved at PGC.
Date Effective	08/01/2022	
Date Archived	03/31/2023	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): www.cms.gov.
2. Mehrara, B. Breast cancer-associated lymphedema. Last updated November 2021. UpToDate Inc. Waltham, MA.
3. Nahabedian, M. Overview of Breast Reconstruction. Last updated April 2021. UpToDate Inc. Waltham, MA.

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

4. National Determination Coverage 140.2 Breast Reconstruction Following Mastectomy Retrieved on 03/07/2022 from www.cms.gov.
5. Sable, M. Breast conserving Therapy. Last updated February 2021. UpToDate Inc. Waltham, MA.

Independent medical review –04/2019

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