MEDICAL POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Breast Reconstruction Surgery-MI MCD-MM-1516	01/01/2025-06/30/2025
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.

Table of Contents

A. Subject

Breast Reconstruction Surgery

B. Background

With an estimated 272,000 new cases yearly, breast cancer continues to be the leading cause of new cancer among women in the United States and a leading cause of cancer death. Breast reconstruction is intended to reduce post-mastectomy complications, establish symmetry between the surgical breast and the contralateral breast, and improve quality of life following breast cancer surgery. Breast reconstruction procedures may include breast reduction, breast augmentation with FDA-approved breast implants, nipple reconstruction (including surgery, tattooing, or both), and breast contouring. Reconstruction may be performed immediately following a mastectomy or can be delayed for weeks or years until the member has undergone radiation, chemotherapy, or decides that reconstruction is wanted.

Breast augmentation with an FDA-approved implant can be performed in one stage, during which the implant is inserted during the same surgical visit as the mastectomy, or in two stages using an implanted tissue expander in the first stage followed by removal of the expander and insertion of the permanent breast implant. Complications may occur from breast implants immediately postoperatively or years later and can include exposure, extrusion, infection, contracture, rupture, and/or pain. Clinically significant complications may require implant removal.

Autologous tissue/muscle breast flap reconstruction is a safe and effective alternative to breast implants. Muscle, subcutaneous tissue, and skin can be transposed from the donor site, either locally (eg, latissimus dorsi myocutaneous [LD] flap, pedicled transverse rectus abdominus myocutaneous [TRAM] flap) or distally (eg, free TRAM flap, deep inferior epigastric perforator [DIEP] flap, superficial inferior epigastric artery perforator [SIEP] flap, inferior or superior gluteal flap, superior gluteal artery perforator flab, Reubens flap, or transverse upper gracilis [TUG] flap). The choice of procedure can be affected by the member's age and health, contralateral breast size and shape, personal preference, and expertise of the surgeon.

Individuals may also select non-invasive options, such as mastectomy bras and external breast prostheses.

Refer to MCG for complete mastectomy.

C. Definitions

- **Breast Conserving Surgery (Lumpectomy, Partial Mastectomy)** – Surgical removal of tumor and small amount of surrounding breast tissue.
- **Contralateral Breast** – Unaffected, nonsurgical breast.

- **Cosmetic Procedures** – Procedures completed to improve appearance and self-esteem and to reshape normal structures of the body.
- **Mastectomy** – Surgical removal of one or both breasts.

D. Policy

I. Breast reconstruction is not gender specific.

II. Prior authorization requirements for specified breast reconstruction procedure codes are waived when billed with appropriate ICD-10 breast cancer diagnosis codes. Refer to the Michigan Medicaid Code and Rate Reference tool for specific CPT codes subject to this prior authorization waiver.

III. Surgical Options

A. HAP CareSource considers breast reconstruction following treatment for breast cancer medically necessary when **ANY** of the following apply:

1. following mastectomy or breast conserving surgery of the affected breast
2. producing a symmetrical appearance on the contralateral breast
3. improve breast function after conservatory therapy and related to significant abnormalities or deformities resulting from **ANY** of the following:
   a. malignant breast disease
   b. congenital deformities affecting the member's physical and psychological well being
   c. severe fibrocystic breast disease that limits the member's function
   d. unintentional trauma or injuries
   e. unintentional complications after breast surgery for non-malignant conditions (eg, pain, irritation, bleeding, discharge, difficulty with lactation)

IV. HAP CareSource considers risk reduction mastectomy medically necessary when **ALL** the following apply:

A. *significantly elevated risk of breast cancer as indicated by **ANY** of the following:*
   1. *member has BRCA1 or BRCA2 genetic mutation, Li-Fraumeni syndrome (TP53 mutation), or Cowden syndrome (PTEN mutation)*
   2. *lifetime risk of new breast cancer diagnosis estimated to be greater than 20%*
   3. *history of mantle chest radiation before age 30 years*

B. *member does not consider alternative approaches to elevated risk (ie, chemoprophylaxis, close observation) as sufficient*

C. *at least 10-year life expectancy*

V. HAP CareSource considers treatment of physical complications, including lymphedema, following breast reconstruction medically necessary.

VI. Surgical Exclusions

A. HAP CareSource does not cover any breast reconstruction procedures that

are considered experimental, investigational, or unproven.

B. HAP CareSource does not cover:
   1. Procedures that are considered cosmetic in nature, including natural changes due to aging or weight loss/gain.
   2. Lipectomy for donor site symmetry.
   3. Suction lipectomy or ultrasonically assisted suction lipectomy (liposuction) for correction of surgically induced donor site asymmetry (eg, trunk or extremity) that results from one or more flap breast reconstruction procedures.

VII. Non-Surgical Alternatives
HAP CareSource covers external breast prostheses and mastectomy bras following mastectomy or breast conserving surgery. All other indications are considered not medically necessary.

VIII. Breast reconstruction with free flap procedures, regardless of technique, applies to CPT code 19364.

E. Conditions of Coverage
N/A

F. Related Policies/Rules
N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	09/27/2023	New policy. Approved at Committee.
Date Revised	04/10/2024 10/23/2024	Annual review: updated references. Approved at Committee Review: updated risk reduction mastectomy and reorganized policy section for clarity. Approved at committee.
Date Effective	01/01/2025	
Date Archived	06/30/2025	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
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The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

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