CareSource

MCDMEDICAL POLICY STATEMENT
OHIO MEDICAID

Policy Name	Policy Number	Date Effective
Screening and Diagnostic Mammography	MM-0051	09/01/2020-03/31/2021

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.

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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** – Low-dose x-rays of the breast that can help find breast cancer. This includes conventional, digital, and 3D.
- **Screening mammogram** – Used to look for signs of breast cancer in women who don't have any breast symptoms or problems.
- **Diagnostic mammogram** – Used to look at a woman's breast if she has breast symptoms or if a change is seen on a screening mammogram.
- **Female at high risk** – Have a lifetime risk of breast cancer of about 20% to 25% or greater, according to risk assessment tools that are based mainly on family history
  - Have a known BRCA1 or BRCA2 gene mutation (based on having had genetic testing)
  - Have a first-degree relative (parent, brother, sister, or child) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves
  - Had radiation therapy to the chest when they were between the ages of 10 and 30 years
  - Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes

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

D. Policy

I. A prior authorization is not required for screening or diagnostic mammography.

II. Mammograms
  A. Screening mammograms
    1. Are covered for women with the following frequency:
      a. Once between ages 35 and 39;
      b. Once per twelve months after age 40; and
      c. When ordered by a practitioner for a female at high risk.
        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. II. A. 1. a. and b. 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.

III. 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	06/06/2016	
Date Revised	10/04/2017 04/29/2020	Changed title from breast imaging – focused on mammograms. Updated policy, background, and definitions.
Date Effective	09/01/2020	
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. Ohio Administrative Code. (2017, January 1). *5160-4-25 Radiology and imaging services.* Retrieved April 8, 2020 from www.codes.ohio.gov
3. American Cancer Society. (2020, March 5). *American Cancer Society Screening Recommendations for Women at High Risk.* Retrieved April 10, 2020 from www.cancer.org
4. American Cancer Society (2020, March 5). *Mammogram Basics*. Retrieved April 14, 2020 from www.cancer.org

Independent medical review – 4/2020