MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Breast Reconstruction Surgery-GA MCD-MM-0732	04/01/2023-01/31/2024
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 is intended to reduce post-mastectomy complications and to establish symmetry between the surgical breast and the contralateral breast. Breast reconstruction procedures may include breast reduction, breast augmentation with FDA-approved breast implants, nipple reconstruction, 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 they want breast reconstruction.

Breast augmentation with an FDA-approved implant can be performed in one stage (where 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 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 (e.g., latissimus dorsi myocutaneous (LD) flap, pedicled transverse rectus abdominus myocutaneous (TRAM) flap) or distally (e.g., 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 flap, Reubens flap, 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 total mastectomy.

C. Definitions

- **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 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.

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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II. Breast reconstruction is not gender specific.

III. Surgical Options
   A. CareSource considers breast reconstruction medically necessary when either of the following apply:
      1. Following mastectomy or breast conserving surgery of the affected breast; or
      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 (e.g., pain, irritation, bleeding, discharge, complications causing difficulty with lactation);
      6. Risk reduction mastectomy.
   C. CareSource considers treatment of physical complications including lymphedema following breast reconstruction 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.
         b. Lipectomy for donor site symmetry.
         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.

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

E. Conditions of Coverage
NA

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F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/01/2020	
Date Revised	02/17/2021 03/16/2022 11/01/2022	Updated Criteria No changes to content. Updated reference dates. Approved at PGC. Added background, references, guidance regarding HCPCS S-codes
Date Effective	04/01/2023	
Date Archived	01/31/2024	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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Independent medical review – 04/2019

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