

MEDICAL POLICY STATEMENT				
Georgia Medicaid				
Policy Name & Number	Date Effective			
Breast Reconstruction Surgery-GA MCD-MM-0732	02/01/2024			
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.

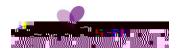
Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the 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.

Table of Contents

Α.	Subject	2
B.	Background	2
C.	Definitions	2
D.	Policy	3
E.	Conditions of Coverage	3
F.	Related Policies/Rules	4
G.	Review/Revision History	4
Н.	References	4

Breast Reconstruction Surgery-GA MCD-MM-0732 Effective Date: 02/01/2024

The MEDICAL Policy Statement detailed above has received due considera



- D. Policy
 - I. Breast reconstruction is not gender specific.
 - II. 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
 - 2. producing a symmetrical appearance on the contralateral breast
 - 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 (eg, pain, irritation, bleeding, discharge, complications causing difficulty with lactation)



F. Related Policies/Rules NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/01/2020	
Date Revised	02/17/2021	Updated Criteria.
	03/16/2022	No changes to content. Updated reference dates.
		Approved at PGC.
	11/01/2022	Added background, references, guidance regarding
		HCPCS S-codes.
	03/01/2023	Updated background. Removed IV. C. Updated
		references.
	09/27/2023	Annual review. Approved at committee.
Date Effective	02/01/2024	
Date Archived		

H. References

- 1. Breast reconstruction surgery. American Cancer Society. Updated September 19, 2022. Accessed 8/28/2023. www.cancer.org
- 2. Centers for Medicare and Medicaid Services. *Women's Health and Cancer Rights Act (WHCRA)*. Accessed August 28, 2023. www.cms.gov
- Costanzo D, Klinger M, Lisa A, Maione L, Battistini A, Vinci V. The evolution of autologous breast reconstruction. *Breast J.* 2020;26(11):2223-2225. doi: 10.1111/tbj.14025
- 4. Colwell AS, Taylor EM. Recent advances in implant-based breast reconstruction. Plast Reconstr Surg. 2020;145(2):421e-432e. doi: 10.1097/PRS.00000000006510
- Friedrich M, Kramer S, Friedrich D, Kraft C, Maass N, Rogmans C. Difficulties of breast reconstruction – problems that no one likes to face. *Anticancer Res.* 2021;41(11):5365-5375. doi: 10.21873/anticanres.15349
- Gradishar WJ, Moran MS, Abraham J, et al. NCCN guidelines insights: breast cancer, version 4.2023. *J Natl Compr Canc Netw.* 2023;21(6):594-608. doi: 10.6004/jnccn.2023.0031
- Health technology assessment: comparative effectiveness review of human acellular dermal matrix for breast reconstruction. Hayes Inc. Reviewed February 28, 2022. Accessed August 28, 2023. www.evidence.hayesinc.com
- Health technology assessment: autologous fat grafting for breast reconstruction after breast cancer surgery. Hayes, Inc. Reviewed November 14, 2022. Accessed August 28, 2023. www.evidence.hayesinc.com
- 9. Nahabedian M. Options for autologous flap-based breast reconstruction. UpToDate. Updated July 11, 2022. Accessed August 28, 2023. www.uptodate.com
- 10. Sable MS. Breast conserving therapy. UpToDate. Updated July 10, 2023. Accessed August 28, 2023. www.uptodate.com