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.

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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)

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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 03/01/2023 09/27/2023	Updated Criteria. No changes to content. Updated reference dates. Approved at PGC. Added background, references, guidance regarding HCPCS S-codes. Updated background. Removed IV. C. Updated references. Annual review. Approved at committee.
Date Effective	02/01/2024	
Date Archived		

H. References

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