Marketplace Benefit Interpretation

Marketplace National Regional Benefit Interpretation Document

Benefit Name	POST MASTECTOMY SURGERY
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, Nevada, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	This policy addresses post mastectomy surgery. Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern. **Essential Health Benefits for Individual and Small Group** For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage. **A. FEDERAL/STATE MANDATED REGULATIONS** **Note: The most current federal/state mandated regulations for each state can be found in the links below.** **FEDERAL:** **Women's Health and Cancer Rights Act of 1998**

- https://www.govinfo.gov/content/pkg/USCODE-2011-title29/html/USCODE-2011-title29-chap18-subchapI-subtitleB-part7-subpartB-sec1185b.htm

- https://www.congress.gov/bill/105th-congress/house-bill/616/text
- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet

CALIFORNIA:

California Health & Safety Code §1367.635: Mastectomy and Reconstructive Surgery Coverage

California Health & Safety Code Section 1367.6: Breast Cancer; Mastectomies

SB 535 (APL 21-025): Prohibits plans, on or after July 1, 2022, from requiring prior authorization for
1) biomarker testing for an enrollee with advanced or metastatic stage 3 or 4 cancer or
2) biomarker testing for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer.

Allows a plan to require prior authorization for biomarker-testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

FLORIDA:

Individual – Fla. Stat. § 627.64171; HMO Contract - Fla. Stat. § 641.31(31) - Post-mastectomy length of stay and out-patient coverage

Individual - Fla. Stat. § 627.6417; HMO Contract - Fla. Stat. § 641.31(32) - Mastectomy: Surgical procedures and devices

IDAHO:

Federal Requirements in Women's Health and Cancer Rights Act of 1998 (P.L. 105-277)- Breast reconstruction, if mastectomy is covered

Congenital Anomaly (e.g., cleft lip and palate)
ID Admin Code 18.01.06: RULE TO IMPLEMENT UNIFORM COVERAGE FOR NEWBORN AND NEWLY ADOPTED CHILDREN

ILLINOIS:

Post-Mastectomy Care

215 ILCS 5/356t
215 ILCS 125/4-6.5

Mastectomy - Reconstruction
P.A. 92-0048
215 ILCS 5/356g(b)- Mammograms; mastectomies
215 ILCS 125/4-6.1- Mammograms; mastectomies

215 ILCS 5/356p; 215 ILCS 125/4-6.2- Implant removal when medically necessary for treatment of sickness or injury. Does not apply for implants implanted solely for cosmetic reasons
215 ILCS 5/356z.53 (ilga.gov)

KENTUCKY:

Breast cancer treatment with high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation
Ky. Rev. Stat. § 304.17-3165: Coverage for treatment of breast cancer
Ky. Rev. Stat. § 304.17A-135: Coverage for treatment of breast cancer
Ky. Rev. Stat. § 304.38-1936: Coverage for treatment of breast cancer
Ky. Rev. Stat. § 304.17-3163: Coverage for medical and surgical benefits with respect to mastectomy, diagnosis and treatment of endometrioses and endometritis, and bone density testing -- Duties of insurer.

Ky. Rev. Stat. § 304.17A-134: Coverage for medical and surgical benefits with respect to mastectomy, diagnosis and treatment of endometrioses and endometritis, and bone density testing -- Requirements for health benefit plan.

MICHIGAN:

MCL500.3406d- Breast cancer outpatient treatment services/Breast cancer rehabilitation services/Mastectomy prosthetics/Breast cancer diagnostic service

MISSISSIPPI:

Mississippi Department of Insurance Regulation 2000-3 Women's Health and Cancer Rights- Breast reconstruction where a mastectomy was performed

NEW MEXICO:

NMSA 59A-22-39.1: Mastectomies and Lymph Node Dissection; Minimum Hospital Stay Coverage
NMSA 59A-46-41.1: Mastectomies and Lymph Node Dissection; Minimum Hospital Stay Coverage Required

SOUTH CAROLINA:

S.C. Code Ann. § 38-71-125: Mastectomies; hospitalization requirements; early release provisions

S.C. Code Ann. § 38-71-130: Breast reconstruction and prosthetic devices

TEXAS:

Texas Insurance Code §1357.002: Applicability of Subchapter A

Texas Insurance Code §1367.003: Women's Health - Mastectomy, Reconstructive Surgery

Texas Insurance Code § 1357.004: Coverage Required

Texas Insurance Code §1357.005: Prohibited Conduct

Texas Insurance Code §1357.006: Notice of Coverage

- An issuer of a health benefit plan that provides coverage under this subchapter shall provide to each enrollee notice of the availability of the coverage.
- The notice must be provided in accordance with rules adopted by the commissioner.

Texas Insurance Code §1357.052: Applicability of Subchapter B

Texas Insurance Code §1357.054: Coverage Required- Women's Health - Mastectomy Or Lymph Node Dissection, Minimum Stay

Texas Insurance Code §1357.055: Prohibited Conduct

Texas Insurance Code §1357.056: Notice of Coverage

- An issuer of a health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.
- The notice must be provided in accordance with rules adopted by the commissioner.

TAC Title 28, Part 1, Chapter 11, Subchapter F Rule §11.508(b)(1): Basic Health Care Services and Mandatory Benefit Standards

28 TAC §11.509(5): Additional Mandatory Benefit Standards: Individual and Group Agreements

28 TAC § 11.508(b)(1): Women's Health - Mastectomy, Reconstructive Surgery

UTAH:

31A-22-630: Mastectomy coverage

WASHINGTON:

RCW 48.46.280: Reconstructive breast surgery.
RCW 48.46.285: Mastectomy, lumpectomy.
WAC 284-43-5642: Essential health benefit categories.

WISCONSIN:

632.895 (13): Breast Reconstruction

B. STATE MARKET PLAN ENHANCEMENTS

None

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

RECONSTRUCTIVE SURGERY

CALIFORNIA:

Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function or create a normal appearance, to the extent possible.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

FLORIDA, IDAHO, MISSISSIPPI, NEVADA, OHIO, SOUTH CAROLINA, WISCONSIN:
Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

IDAHO: Molina covers Medically Necessary services related to treatment of a congenital anomaly. A congenital anomaly is a condition existing at or from birth that is a significant deviation from the common form or function of the body, impairing the function of the body, whether caused by a hereditary or developmental defect or disease.

ILLINOIS:
Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive or cosmetic surgery to correct or repair abnormal structures of the body caused by congenital defects, conditions resulting from accidental injuries, developmental abnormalities, scars, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.
- Breast reduction surgery if medically necessary**.**
- Removal of breast implant if medically necessary.

KENTUCKY:
Reconstructive Surgery: Passport covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.

- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery, and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

MICHIGAN:
Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

The following Medically Necessary surgeries:

- Blepharoplasty of upper lids
- Breast reduction
- Surgical treatment of male gynecomastia
- Panniculectomy
- Sleep apnea treatments – including rhinoplasty and septorhinoplasty

NEW MEXICO:
Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.
- Medically necessary services related to gender affirming care and the treatment for gender dysphoria

TEXAS:

	Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized: • Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function. • Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas • For a child who is younger than 18 years of age, Molina covers reconstructive surgery for craniofacial abnormalities. Such coverage includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. **UTAH:** **Reconstructive Surgery**: Molina covers the following reconstructive surgery services when Prior Authorized: • Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function. • Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas. • <u>Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.</u> **WASHINGTON:** **Reconstructive Surgery**: Molina covers the following reconstructive surgery services when Prior Authorized: • Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function, including for newborn Members.

- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery, and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

ALL STATES:
For Covered Services related to reconstructive surgery, you will pay the Cost Sharing the member would pay if the Covered Services were not related to reconstructive surgery. For example, for hospital inpatient care, you would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Schedule of Benefits.

CANCER TREATMENT

CALIFORNIA:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the BI Policy titled Preventive Care Services for more information)
- Biomarker testing with no requirement for Prior Authorization for a Member with advanced or metastatic stage 3 or 4 cancer
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the BI Policies titled "Reconstructive Surgery" and "DME, Prosthetic, and Medical Supplies" sections of this Agreement for more information)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the BI Policy titled Clinical Trials for more information)
- Prescription medications to treat cancer (please refer to the Benefit Interpretation Policy titled Medications and Off-Label Drugs for more information)

FLORIDA:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Policy)
- Diagnostic screening, laboratory, and procedures

- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer.
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices section of the DME Policies)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Policy)

IDAHO:
Cancer Treatment: Molina provides the following coverages for cancer prevention, screening, care, and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Benefit Policy)
- Mammogram coverage at the following periodicity:
  - One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
  - A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
  - A mammogram every year for any woman who is fifty (50) years of age or older.
  - A mammogram for any woman desiring a mammogram for medical cause.
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices Benefit Policies)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Benefit Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Benefit Policy)

ILLINOIS:

Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Benefit Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and DME and Prosthetic Benefit Policies)
- Medically Necessary proton beam therapy
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Benefit Policy)
- Prescription medications to treat cancer (please refer to the Medication and Prescription Drug Benefit Policy)
- Breast - Fibrocystic Breast Condition
- Biomarker testing, including one, Medically Necessary, home saliva cancer screening every 24 months if the Member is:
    - Asymptomatic and at high risk for the disease; or
    - Demonstrates symptoms of the disease being tested for during physical examination.

Pancreatic Cancer Screening (Medically Necessary) and as required by state law

KENTUCKY:
Cancer Treatment: Passport provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Benefit Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)

- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Benefit Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Benefit Policy)
- Mammograms
- High-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation, according to guidance from the American Society for Blood Marrow Transplantation or the International Society of Hematotherapy and Graft Engineering, whichever has the higher standard

MICHIGAN:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive care screening and testing (please refer to the Preventive Services Benefit Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the "Reconstructive Surgery" and "DME and Prosthetic" Benefit Policies)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer
- Prescription medications to treat cancer (please refer to the Prescription Drug Benefit Policy)

MISSISSIPPI:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive surgery and Prosthetic and Orthotic Devices Policies)

- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Policy)

NEVADA:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices sections of this Agreement for more information)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for more information)
- Medically Necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer.

If the Policy covers the treatment of prostate cancer, it must provide coverage for prostate cancer screening.

NEW MEXICO:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Benefit Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections (not less than 48 hours of inpatient care following a mastectomy and 24

hours of inpatient care following a lymph node dissection for the treatment of breast cancer)
- Mastectomy-related services (please refer to the Reconstructive Surgery and DME and Prosthetic Benefit Policy)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer
- Prescription medications to treat cancer (please refer to the Medications and Prescription Drug Benefit Policy)
- Skin cancer behavioral counseling (age 6 months to 24 years)

OHIO:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:
- Preventive care screening and testing (please refer to the Preventive Services Benefit Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast), four post-mastectomy surgical bras, and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and DME and Prosthetic Benefit Policy)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Benefit Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Benefit Policy)

SOUTH CAROLINA:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:
- Preventive screening and testing (please refer to the Preventive Services Benefit Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer. Coverage allows at least 48 hours of hospitalization following a mastectomy. In the case of an early

release, coverage shall include at least one home care visit if ordered by the attending physician.

- Mastectomy-related services (please refer to the Reconstructive Surgery and DME and Prosthetic Benefit Policies)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (Please refer to the Approved Clinical Trial Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Benefit Policy)

TEXAS:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices Policy)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drugs Policy)

UTAH:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Benefit Policy)
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and DME and Prosthetic Benefit Policies)

- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Benefit Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug section of this Agreement for full details). Molina covers prescribed oral chemotherapy and intravenously administered chemotherapy in parity.

WASHINGTON:
Cancer Treatment: Molina provides the following coverages for cancer prevention, screening, care, and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Benefit Policy)
- Mammogram services, including both diagnostic breast examination and supplemental breast examinations (without Member Cost Sharing)
- Diagnostic breast examination means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, digital breast tomosynthesis, also called three-dimensional mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or detected by another means of examination.
- Supplemental breast examination means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is used to screen for breast cancer when there is no abnormality seen or suspected and based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.
- Colorectal screening for all adults age of forty-five (45) and older or colorectal screening for Members less than fifty (50) years old and at high risk or very high risk for colorectal cancer. Molina does not impose Cost Sharing for the following services that are integral to performing the colonoscopy:
    - Required specialist consultation prior to the screening procedure;
    - Bowel preparation medications prescribed for the screening procedure;
    - Anesthesia services performed in connection with a preventive colonoscopy;
    - Polyp removal performed during the screening procedure; and

- Any pathology exam on a polyp biopsy performed as part of the screening procedure; or
- A colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without Cost Sharing

- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices Benefit Policies)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Benefit Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Benefit Policy)
- Biomarker testing services, when prescribed by a Participating Provider, are not subject to Prior Authorization requirements for Members with stage 3 or 4 cancer or for Members with recurrent, relapsed, refractory, or metastatic cancer.

WISCONSIN:
Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services Policy)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the Reconstructive Surgery and Prosthetic and Orthotic Devices Policies)
- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the Approved Clinical Trial Policy)
- Prescription medications to treat cancer (please refer to the Prescription Drug Policy)

EXTERNAL DEVICES

VARIES FOR EACH MP STATE:

Please refer to the **DME, Prosthetics and Orthotic Devices** Benefit Interpretation Policy for more information on prosthesis after mastectomy

MORE INFORMATION

Refer to the Benefit Interpretation Policies titled **Chemotherapy, Preventive Care Services** and **DME, Prosthetics and Orthotic Devices and Medications and Off-Label Drugs** for additional information.

D. NOT COVERED

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

RECONSTRUCTIVE SURGERY

ALL STATES:

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body to improve appearance
- Surgery that does not result in a clinically significant improvement in a normal body function is not covered (Clinical)

E. DEFINITIONS

See Glossary

F. REFERENCES

Women's Health and Cancer Rights Act of 1998

G. POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
4/15/2021	• Added KY Drafted 2022 Language
5/14/2021	• Added IL 2022 EOC Language

	6/30/2021	• Added ID 2022 Language
	7/1/2023	• Added NV 2024 Language
Codification	Marketplace Benefit Interpretation Policies Codification	
Prior Authorization	For the MHI PA Matrix, if a code is NOT listed, it could EITHER be: a. Covered and No PA Required b. Not Covered You cannot use the MHI PA Matrix to make coverage determinations. PA Lookup Tool	

Approval	Departments	Product	CIM	Clinical Management
	Date	4/6/2021	5/21/2021	4/21/2021
	Revised (for 1/1/2022)	11/16/2021	3/2/2022	11/29/2021
	Revised (for 1/1/2023)	11/17/2022	4/12/2023	12/13/2022
	Revised (for 1/1/2024)	11/30/2023	4/1/2024	12/8/2023
	Revised (for 1/1/2025)	11/12/2024	-	11/12/2024