MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**REDUCTION MAMMAPLASTY**
Policy Number	**7.01.39**
Category	**Cosmetic**
Effective Date	**10/18/01**
Revised Date	**05/23/02, 10/02/02, 12/11/03, 12/02/04, 02/23/06, 02/22/07, 06/26/08, 06/25/09, 06/24/10, 06/24/11, 06/28/12, 09/04/12, 08/22/13**
Archived Date	**08/28/14**
Edited Date	**08/27/15, 08/25/16, 08/25/17, 08/23/18, 08/22/19**
Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.* • *If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.*

POLICY STATEMENT

I. Based upon our criteria and review of the peer-reviewed literature, reduction mammaplasty has been proven to be effective and therefore **medically necessary** when the criteria of statements A, B, and C below have been met:
   A. At least two of the following persistent physical symptoms, affecting activities of daily living, have been present at least two years:
      1. Back, neck and/or shoulder pain;
      2. Breast pain;
      3. Paresthesias of the hands and/or arms;
      4. Permanent shoulder grooving; or
      5. Intertrigo;

   AND

   B. Macromastia/gigantomastia – defined as wearing a bra with a cup size greater than or equal to “D”;

   AND

   C. Usually an estimated tissue resection of at least 500 grams of tissue per breast or 1,000 grams bilaterally. *(Refer to Policy Guideline II).*

II. Based upon our criteria and review of the peer-reviewed literature, reduction mammaplasty is **not medically necessary** for patients with pendulousness, problems with the fitting of clothes, and nipple-areolar distortion.

III. Reduction mammaplasty in females under the age of 18 years is generally **not medically appropriate**, as maturation has not been completed. Maturation of the breasts is usually considered to be completed when the patient’s bra size has not changed in the past three years.

IV. Reduction mammaplasty of the contralateral breast in a patient who has undergone a mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) is considered **medically appropriate** per New York State law. *(Refer to the Description section for further information regarding the law.)*

Refer to Corporate Medical Policy # 7.01.11 regarding Cosmetic and Reconstructive Procedures for breast procedures not included in specific Health Plan medical policies (e.g., Mastopexy).

Refer to Corporate Medical Policy # 10.01.01 regarding Breast Reconstruction Surgery.

POLICY GUIDELINES

I. Resection of at least 500 grams of natural breast tissue (not synthetic tissue such as breast implants) per breast or 1,000 grams bilaterally, with associated symptoms, is the minimum amount of breast tissue necessary to be estimated for removal. Individual consideration for varying statures (e.g., small) will be based upon review by a Health Plan Medical Director utilizing the patient's medical record (including, but not limited to, the patient's height, weight, severity of symptoms, and/or photographs) in conjunction with the criteria stated in policy statements IA and IB.

II. Additionally, the Schnur Sliding Scale, which suggests a minimum amount of breast tissue per breast to be removed for the procedure to be considered medically necessary, based on the patient's body surface area, may be utilized in assisting with the decision making process.

Schnur Sliding Scale

BSA (in meters squared)	Breast Weight (g)	
	Lower 5%	Lower 22%
1.35	127	199
1.40	139	218
1.45	152	238
1.50	166	260
1.55	181	284
1.60	198	310
1.65	216	338
1.70	236	370
1.75	258	404
1.80	282	441
1.85	308	482
1.90	335	527
1.95	367	575
2.00	401	628
2.05	439	687
2.10	479	750
2.15	523	819
2.20	572	895
2.25	625	978

2.30	682	1068
2.35	745	1167
2.40	814	1275
2.45	890	1393
2.50	972	1522
2.55	1062	1662

To calculate the Body Surface Area (BSA):
BSA = the square root of height (in) times weight (lbs) divided by 3,131, or
the square root of height (cm) times weight (kg) divided by 3,600.

A clinical calculator is available online at: http://www.calculator.net/body-surface-area-calculator.html.

If breast weight is above the 22nd percentile the surgery may considered medically necessary, while those below the 5th percentile may be considered cosmetic, and those falling between the lines may have mixed reasons for the procedure.

III. Documentation of the patient's height, weight and the estimated amount of breast tissue to be removed must be included in the letter of medical necessity. In addition, photographs may be beneficial.

IV. If the reduction mammaplasty is performed post-mastectomy on the contralateral breast to match the prosthesis size these requirements do not apply.

DESCRIPTION

Female breast hypertrophy, or macromastia, is the development of abnormally large breasts in the female. This condition can cause significant clinical manifestations, when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk, by the presence of persistent, painful physical signs and symptoms (e.g., shoulder grooving, intertrigo, neck and back pain or paresthesia). Symptoms associated with macromastia may be relieved by reduction mammaplasty surgery.

A reduction mammaplasty, also known as reduction mammoplasty or breast reduction, is the surgical excision of a substantial portion of the breast, including the skin and underlying glandular tissue. The reduction mammaplasty reduces the size, changes the shape, and/or lifts the tissue of the breast.

Various techniques may be utilized in order to perform reduction mammaplasty. The appropriate surgical approach should be determined by the physician and patient in accordance with the patient's clinical situation.

New York State Insurance Law § 4303, 3221, 3216 mandates coverage under all contracts that provide medical, major medical, or similar comprehensive-type coverage for:

I. All stages of breast reconstruction of the breast on which the mastectomy or partial mastectomy, has been performed; and
II. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

RATIONALE

Reduction mammaplasty is a surgical procedure and is not subject to regulatory approval.

Reduction mammoplasty is generally performed to relieve symptoms related to the heaviness and the size of the breasts. Studies have shown that a significant number of women undergoing bilateral breast reduction experience postoperative improvement of chronic neck, back, and shoulder pain. Additional benefits include increased participation in exercise programs, as well as other physical and social activities.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

CPT Codes

Code	Description
19318	Reduction mammaplasty

Copyright © 2019 American Medical Association, Chicago, IL

HCPCS Codes

Code	Description
No code(s)	

ICD10 Codes

Code	Description
N62	Hypertrophy of breast

REFERENCES

American Society of Plastic Surgeons. Evidence-based clinical practice guideline: reduction mammaplasty. [http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Reduction_Mammaplasty_Evidence_Based_Guideline%20%282%29%282%29.pdf] accessed 6/25/19.

BlueCross BlueShield Association. Reduction mammoplasty for breast-related symptoms. Medical Policy Reference Manual Policy #7.01.21. 2019 Feb 14.

Slezak S1. ASPS Health Policy Committee. ASPS clinical practice guideline summary on reduction mammaplasty. Plast Reconstr Surg 2012 Oct;130(4):785-9.

New York State Consolidated Insurance Laws, Section § 4303 (x) (1), 3221 (10) A, 3216 (18) (A).

Noone RB. An evidence-based approach to reduction mammaplasty. Plast Reconstr Surg 2010 Dec;126(6):2171-6.

*Schnur PL, et al. Reduction mammaplasty: cosmetic or reconstructive procedure? Ann Plast Surg 1991 Sep;27(3):232-7.

Singh KA and Losken A. Additional benefits of reduction mammaplasty: a systematic review of the literature. Plast Reconstr Surg 2012 Mar;129(3):562-70.

*Key Article

KEY WORDS

Breast reduction, Mammaplasty, Mammoplasty, Reduction mammaplasty, Reduction mammoplasty.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2) that includes the reconstruction of contralateral unaffected breast following a medically necessary mastectomy as covered: https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=64&ncdver=1&bc=AgAAQAAAAAAAAA%3d%3d&

There is currently a Local Coverage Determination addressing Reduction Mammaplasty. Please refer to the following website for Medicare members: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35001&ver=4&DocType=All&bc=AgIAAAAAAAAAA%3d%3d&