# MEDICAL POLICY

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| **Medical Policy Title** | **Reduction Mammaplasty (Mammoplasty)** |
| **Policy Number** | **7.01.39** |
| **Current Effective Date** | **July 16, 2026** |
| **Next Review Date** | **July 2027** |

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

**This policy does not address reduction mammaplasty for males, refer to InterQual.**

## POLICY STATEMENT(S)

Post-Mastectomy

I. Reduction mammaplasty (also known as reduction mammoplasty or breast reduction) performed to achieve symmetry of the contralateral (opposite) breast following a mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) is considered **medically appropriate** consistent with Federal and New York State law (see Regulatory Section).

Symptomatic Macromastia

II. Reduction mammaplasty is considered **medically appropriate** for the treatment of symptomatic macromastia when **ALL** of the following criteria are met:

A. The individual is at least 18 years of age or has completed breast growth with documented stable breast size for at least one (1) year;

B. At least two (2) of the following persistent physical symptoms have affected activities of daily living for at least one (1) year:

1. Back, neck, or shoulder pain;
2. Breast pain;
3. Headache;
4. Upper extremity paresthesia;
5. Persistent shoulder grooving from bra straps; **or**
6. Intertrigo at the inframammary fold;

C. The planned amount of breast tissue to be removed per breast meets **either** of the following:

1. At least the 22$^{nd}$ percentile on the Schnur Sliding Scale based on the individual's body surface area (BSA) (see Policy Guideline III); **or**
2. At least 500 grams per breast or 1,000 grams bilaterally, regardless of BSA.

III. Reduction mammaplasty is considered **not medically necessary** when the above criteria are not met, including but not limited to asymptomatic macromastia or pendulous breasts, difficulty with clothing fit, or nipple-areolar distortion.

## RELATED POLICIES

Corporate Medical Policy

7.01.11 Cosmetic and Reconstructive Procedures

10.01.01 Breast Reconstruction Surgery

## POLICY GUIDELINE(S)

I. Medical record documentation must include a detailed description of symptoms (including functional impairments and duration of symptoms), the patient's height and weight, and the amount of breast tissue to be removed (in grams). Photographs may be beneficial and may be requested as part of the medical necessity review.

II. The Schnur Sliding Scale is a guideline that establishes a minimum per-breast tissue resection weight based on BSA. Resection weights at or above the 22nd percentile are considered to meet the required threshold, while resection weights below the 22nd percentile are considered cosmetic. BSA may be calculated using either the Mosteller or Du Bois formula.

III. When choice of formula results in differing eligibility determinations for requests near the 22$^{nd}$ percentile threshold, individual consideration will be based on a review by a Health Plan Medical Director, using the individual's medical record in conjunction with policy criteria.

| **Schnur Sliding Scale (Lower 22$^{nd}$ Percentile)** | |
|---|---|
| BSA (in meters squared [$m^2$]) | Minimum grams of breast tissue to be removed (per breast) |
| 1.35 | 199 |
| 1.40 | 218 |
| 1.45 | 238 |
| 1.50 | 260 |
| 1.55 | 284 |
| 1.60 | 310 |
| 1.65 | 338 |
| 1.70 | 370 |
| 1.75 | 404 |
| 1.80 | 441 |
| 1.85 | 482 |
| 1.90 | 527 |
| 1.95 | 575 |

| | |
|---|---|
| 2.00 | 628 |
| 2.05 | 687 |
| 2.10 | 750 |
| 2.15 | 819 |
| 2.20 | 895 |
| 2.25 | 978 |
| 2.30 | 1068 |
| 2.35 | 1167 |
| 2.40 | 1275 |
| 2.45 | 1393 |
| 2.50 | 1522 |
| 2.55 | 1662 |

## DESCRIPTION

Breast hypertrophy, or macromastia, is a condition characterized by excessive breast tissue that causes persistent physical symptoms due to increased breast volume and weight. The resulting mechanical strain on the musculoskeletal system commonly leads to neck, back, and shoulder pain; painful shoulder grooving from bra straps; inframammary intertrigo; headaches; breast pain; and upper extremity paresthesias. Gigantomastia is a rare form of macromastia characterized by excessive breast growth that may occur during puberty or pregnancy, or with the use of certain medications.

Reduction mammaplasty is the surgical excision of excess skin and underlying breast tissue to reduce breast volume. When performed for symptomatic macromastia, the goal is to relieve pain and improve functional impairment.

Breast development in adolescents progresses through recognized stages of maturation (Tanner stages I–V), typically reaching full maturity by Tanner stage V. However, the timing of breast maturity varies considerably among individuals and may be influenced by body habitus. For the purposes of surgical timing, breast maturity should be assessed using Tanner staging, with postmenarcheal status and documented stability of breast size as supportive indicator of maturity.

The Schnur Sliding Scale (Schnur 1991) is an objective tool used to help differentiate between cosmetic and medically necessary reduction mammaplasty. It was developed in response to a need from health insurance carriers for an evidence-based method to evaluate medical necessity. Using data collected from plastic surgeons, Schnur and colleagues created a scale correlating body surface area (BSA) with the weight of breast tissue removed. The scale stratifies individuals into three groups based on resection weight relative to BSA, with a weight at or above the 22nd percentile considered medically necessary. Despite its known limitations as a predictor of resection weight, the Schnur Sliding Scale remains widely used as criterion for reduction mammaplasty.

## SUPPORTIVE LITERATURE

Studies have consistently demonstrated that reduction mammaplasty results in significant

improvement in symptoms related to macromastia, including chronic neck, back, and shoulder pain. Additional documented benefits include improvements in respiratory function, sleep, headaches, and psychological outcomes (e.g., self-esteem, sexual function, and quality of life), as well as increased participation in exercise programs and other physical and social activities (Singh and Losken 2012; Hernanz 2016; Elfanagely 2021; Torresetti 2022; Crittenden 2023; Wang 2023).

Kerrigan et al (2002) conducted the BRAVO (Breast Reduction: Assessment of Value and Outcomes) trial, a prospective multicenter study, to assess existing prediction rules for reduction mammaplasty eligibility. The authors reported that neither the Schnur Sliding Scale nor the 500-gram minimum rule was able to successfully predict which group of women would gain greater improvement from surgery. The BRAVO study proposed a symptom-based definition of medical necessity using a Physical Symptoms Count instrument assessing seven symptoms: upper back pain, neck pain, shoulder pain, numbness, arm pain, bra strap grooves, and rashes. The presence of two or more of these symptoms, occurring most or all of the time, successfully differentiated surgical candidates from controls (89.9% vs. 2%).

Lin et al (2021) conducted a systematic review and meta-analysis of randomized controlled trials (RCTs) (N=285) comparing reduction mammaplasty with a control intervention (nonoperation or physiotherapy exercises) for the treatment of breast hypertrophy. Four RCTs were included in meta-analyses reporting on change in pain, physical function, and psychological function after interventions. The analysis confirmed statistically significant ($p<.00001$) post-operative improvements in pain, physical function, and psychological function compared to the control intervention. The authors concluded that mammaplasty had a positive and significant effect on health-related quality of life, including pain, physical, and psychological functioning, in individuals with breast hypertrophy.

Adolescents (under 18 years of age)

The evidence supports reduction mammaplasty in adolescents with symptomatic macromastia. Prospective studies have demonstrated significant and sustained improvements in pain, physical function, self-esteem, and quality of life; with complication rates comparable to those observed in adults (Nuzzi 2017; Nuzzi 2019; Hudson 2021; Morrison 2023; Payne 2023). Current evidence does not support strict age-based exclusions; rather, individualized assessment based on breast maturity, symptom severity, and physiologic and emotional readiness is recommended.

Nuzzi et al (2020) conducted a cross-sectional study reviewing the medical records of 481 women aged 12 to 21 years who underwent reduction mammaplasty to predict the optimal timing, or biological “sweet spot,” for reduction mammaplasty to minimize the risk of breast regrowth in adolescents. Surgery performed less than 3 years after menarche increased the likelihood of glandular regrowth by over 700 percent in healthy-weight and overweight subjects (OR, 7.43; 95% CI, 1.37 to 40.41). Breast size appears to stabilize considerably later in obese adolescents, and breast growth in obese macromastia patients may not end until 9 years after menarche; operating on obese women before this time point increased the likelihood of glandular breast regrowth by almost 120 percent (OR, 1.18; 95% CI, 1.11 to 1.26). The authors concluded that these findings suggest that age restrictions imposed by care providers and third-party payors may be arbitrary. Surgical readiness should be determined on an individual basis incorporating the patient’s biological and psychological maturity, obesity status, potential for postoperative benefit, and risk tolerance for

postoperative breast growth.

## PROFESSIONAL GUIDELINE(S)

The American College of Obstetricians and Gynecologists Committee Opinion No. 686 (2017; reaffirmed in 2020 and 2024) acknowledged that breast reduction surgery in adolescents with large breasts can relieve back, shoulder, and neck pain.

- Adolescent recommendations for timing of surgery include postponing surgery until breast maturity is reached, waiting until there is stability in cup size over 6 months, and waiting until the age of 18 years. Although there is no one consensus on timing, it may reasonably be determined by the severity of symptoms.

In 2022, the American Society of Plastic Surgeons (ASPS) (Perdikis 2022) issued a revised guideline through a multidisciplinary workgroup consisting of the American Society of Plastic Surgeons, the American Society of Breast Surgeons, and the American Physical Therapy Association.

- Strong recommendation that post-menarche female patients presenting with breast hypertrophy should be offered reduction mammaplasty surgery as first-line therapy over nonoperative therapy based solely on the presence of multiple symptoms rather than resection weight. This indicates that reduction mammaplasty is considered standard of care for symptomatic patients, even without documentation of symptoms for a significant length of time.

The ASPS 2022 guideline acknowledged that numerous studies, including the BRAVO study conducted by Kerrigan and colleagues in 2002, have demonstrated the lack of correlation between the amount of resected weight and symptomatic relief. The society reported evidence demonstrating that resection weight does not accurately predict patient-oriented outcomes such as alleviation of pain and related symptoms; therefore, resected weight should not be the primary determinant of medical necessity.

## REGULATORY STATUS

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that mandates coverage of all stages of reconstructive surgery (including surgery and reconstruction of the other breast to produce symmetrical appearance, prostheses, and treatment of complications following mastectomy) for all group health plans, whether insured or self-funded, that provide medical and surgical benefits, including for mastectomies.

New York State Insurance (ISC) Laws mandate coverage for surgery and reconstruction of the contralateral breast or chest wall to produce a symmetrical appearance after a mastectomy or partial mastectomy; in the manner determined by the attending physician and the patient to be appropriate.

## CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational

- (NMN)=Not medically necessary/appropriate

**CPT Codes**

| Code | Description |
|---|---|
| 19318 | Breast reduction |

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**HCPCS Codes**

| Code | Description |
|---|---|
| Not Applicable | |

**ICD10 Codes**

| Code | Description |
|---|---|
| Multiple Codes | |

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## SEARCH TERMS

Not Applicable

## CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Breast Reconstruction Following Mastectomy (NCD 140.2) [accessed 2026 Jun 18]

Reduction Mammaplasty (LCD L35001) [accessed 2026 Jun 18]

## PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) 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.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

## POLICY HISTORY/REVISION

### Committee Approval Dates

09/16/99, 01/04/01, 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, 08/28/14, 08/27/15, 08/25/16, 08/25/17, 08/23/18, 08/22/19, 08/27/20, 08/19/21, 08/18/22, 07/20/23, 07/18/24, 07/17/25, 07/16/26

| Date | Summary of Changes |
|---|---|
| 10/02/26 | • Policy edit to clarify “per breast” to the Schnur Sliding Scale content in the Policy Guidelines. |
| 07/16/26 | • Annual review; replaced <18 not medically necessary criteria with medically necessary criteria; minor editorial updates for clarity. |

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| 07/17/25 | • Annual review, reduced the required duration of persistent physical symptoms and the required duration of unchanged bra cup size. |
| 01/01/25 | • Summary of changes tracking implemented. |
| 09/16/99 | • Original effective date |