

MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	Reduction Mammoplasty (Mammoplasty)
Policy Number	7.01.39
Category	Contract Clarification
Original Effective Date	10/18/01
Committee Approval Date	10/18/01, 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
Current Effective Date	07/18/24
Archived Date	08/28/14
Archive Review Date	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
Product Disclaimer	<ul style="list-style-type: none"> • <i>Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.</i> • <i>If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.</i> • <i>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.</i> • <i>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.</i> • <i>If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.</i>

POLICY STATEMENT

- I. Reduction mammoplasty (also known as reduction mammoplasty or surgical breast reduction) performed to produce symmetrical appearance of the contralateral breast in a patient who has undergone a mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) is considered **medically appropriate** under Federal and New York State law. (Refer to Policy Guidelines)
- II. Based upon our criteria and assessment of the peer-reviewed literature, reduction mammoplasty has been medically proven to be effective and, therefore, is considered **medically appropriate** for the treatment of symptomatic macromastia when **ALL** of the following criteria are met:
 - A. Activities of daily living are affected for at least two (2) years, with at least two (2) of the of the following persistent physical symptoms:
 1. Back, neck, or shoulder pain;
 2. Breast pain;
 3. Paresthesia of the hands or arms;
 4. Permanent shoulder grooving; or
 5. Intertrigo (rash) at the inframammary fold; **and**
 - B. The estimated amount of natural breast tissue to be removed per breast meets **ONE (1)** of the following criteria:
 1. Based on the patient's body surface area (BSA), the planned resected weight meets the Schnur Sliding Scale lower 22% for the minimum breast tissue to be removed. (*Refer to Policy Guideline III.*); **or**
 2. Irrespective of the patient's BSA, the planned resected weight is a minimum of 500 grams of breast tissue per breast, or 1,000 grams bilaterally.

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- III. Based upon our criteria and assessment of the peer-reviewed literature, reduction mammoplasty is considered **not medically necessary** for patients whose only symptoms are pendulousness, problems with the fitting of clothes, and nipple-areolar distortion.
- IV. Reduction mammoplasty in females under age 18 years is generally considered **not medically necessary**, 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.

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

Refer to Corporate Medical Policy #7.01.84 Gender Affirming Surgery and Treatments for Commercial and Medicare Advantage Members

Refer to Corporate Medical Policy #10.01.01 Breast Reconstruction Surgery

Refer to InterQual criteria for Reduction Mammoplasty, Male

POLICY GUIDELINES

- I. New York State Consolidated 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.
- 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 other breast to produce symmetrical appearance, prosthesis, 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.
- II. Medical record documentation must include a detailed description of experienced 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). In addition, photographs may be beneficial and may be requested as part of the medical necessity review. 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 in conjunction with the criteria set forth in the policy statements above.
- III. The Schnur Sliding Scale is an objective tool that suggests a minimum amount of breast tissue per breast to be removed, based on the patient's body surface area (BSA), for the procedure to be considered medically appropriate. A reduction mammoplasty may be considered medically appropriate when the expected removed breast tissue weight meets the 22nd percentile shown below. The surgery may be considered cosmetic when the expected removed breast tissue weight is below the 22nd percentile.

Schnur Sliding Scale

BSA (in meters squared)	Lower 22% Minimum amount of breast tissue to be removed (in grams)
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284

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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

To calculate the Body Surface Area (BSA):

BSA = the square root of height (inches) multiplied by weight (lbs.) divided by 3,131; or
the square root of height (cm) multiplied by weight (kg) divided by 3,600.

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

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. Macromastia is characterized by the presence of persistent, painful physical signs and symptoms (e.g., shoulder grooving, intertrigo, neck and back pain or paresthesia), which may be relieved by reduction

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mammoplasty surgery. Gigantomastia is a rare condition characterized by excessive breast growth. It may occur spontaneously, during puberty or pregnancy, or while taking certain medications.

A reduction mammoplasty is the surgical excision of a substantial portion of the breast, including the skin and underlying glandular tissue. The goal of medically necessary reduction mammoplasty is to relieve symptoms of pain and disability. The reduction mammoplasty reduces the size, changes the shape, and/or lifts the tissue of the breast.

RATIONALE

Reduction mammoplasty is a surgical procedure and is not subject to regulatory approval. Reduction mammoplasty is generally performed to relieve symptoms related to the heaviness and 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.

In 2022, the American Society of Plastic Surgeons (ASPS) revised their 2012 guideline through a multidisciplinary workgroup consisting of members of the American Society of Plastic Surgeons, the American Society of Breast Surgeons, the American Physical Therapy Association (Perdikis et al., 2022). Based on high-quality evidence the committee made a strong recommendation that post menarche female patients presenting with breast hypertrophy should be offered reduction mammoplasty surgery as first-line therapy over nonoperative therapy based solely on the presence of multiple symptoms rather than resection weight. Indicating that reduction mammoplasty 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 (Kerrigan et al., 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, the recommendation is that resected weight should not be the primary determinant of medical necessity.

The American College of Obstetricians and Gynecologists issued a committee opinion in 2017 (reaffirmed in 2020) acknowledging that breast reduction surgery in adolescents with large breasts can relieve back, shoulder, and neck pain. 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.

Kerrigan et al. (2002) conducted the Breast Reduction: Assessment of Value and Outcomes (BRAVO) study to assess the existing prediction rules for reduction mammoplasty 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 Schnur Sliding Scale (Schnur et al., 1991) is an objective evaluation method used by physicians to evaluate individuals considering breast reduction surgery. It was created in response to call from health care insurance companies for medical literature distinguishing between cosmetic and medical necessity. Schnur et al. (1991) concluded that if the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically necessary with the appropriate criteria. If the individual's body surface area and weight of breast tissue removed fall below the lower 22nd percentile, then the surgery is deemed not medically necessary.

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.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/appropriate = (NMN).*

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Code	Description
19318	Breast reduction

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Code	Description
No code(s)	

ICD10 Codes

Code	Description
Numerous Codes	

REFERENCES

American College of Obstetricians and Gynecologists. Breast and labial surgery in adolescents. Committee Opinion No. 686. Obstet Gynecol 2017 Jan [reaffirmed 2020];129(1):e17-e19.

American Society of Plastic Surgeons. ASPS recommended insurance coverage criteria for third-party payers. Reduction mammoplasty. 2011 May [updated Mar 2021]. [<https://www.plasticsurgery.org/documents/Health-Policy/Reimbursement/insurance-2021-reduction-mammoplasty.pdf>] accessed 06/18/24.

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*New York State Consolidated Insurance (ISC) Laws. Chapter 28, Article 32. Standard provisions. Section § 3221 (10) (A)(ii), [<https://www.nysenate.gov/legislation/laws/ISC/3221>] accessed 06/18/24.

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*Key Article

KEY WORDS

Breast reduction, Mammoplasty, Mammoplasty, Reduction mammoplasty, 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:

[\[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=64&ncdver=1&bc=AgAAQAAAAAAAAAA%3d%3d&\]](https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=64&ncdver=1&bc=AgAAQAAAAAAAAAA%3d%3d&) accessed 06/18/24.

There is currently a Local Coverage Determination (LCD) addressing Reduction Mammoplasty (L35001). Please refer to the following website for Medicare members:

[\[https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35001&ver=8&DocType=All&bc=AgIAAAAIAAA&\]](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35001&ver=8&DocType=All&bc=AgIAAAAIAAA&) accessed 06/18/24.