MN. 022.A Reduction Mammoplasty

Original Implementation Date : 8/1/2023
Version [A] Date : 8/1/2023
Last Reviewed Date: May 2024

PRODUCT VARIATIONS

This policy applies to all lines of business unless noted below.

LCD L35001 Reduction Mammoplasty applies for Medicare LOB.

POLICY STATEMENT

REDUCTION MAMMOPLASTY

We consider reduction mammoplasty medically necessary for non-cosmetic indications for women aged 18 or older or for whom growth is complete (i.e., breast size stable over one year) when *any* of the following criteria listed below are met:

Macromastia

1) Member has at least **one** of the following conditions/symptoms directly attributed to macromastia and affecting daily activities for at least 1 year:

    1. Shoulders, upper back/neck pain/or ulnar nerve palsy for which no other etiology has been found on appropriate evaluation.

    2. Skin breakdown/infection (intertrigo, dermatitis, eczema, or hidradenitis) at the inframammary fold.

2) **All** the following criteria must be met:

    1. Member has severe breast hypertrophy, documented by high-quality color frontal-view and side-view photographs; *and*

2. There is a reasonable likelihood that the member's symptoms are primarily due to macromastia; and

3. Reduction mammoplasty is likely to result in improvement of the chronic pain; and

4. Symptoms of pain persist as documented by the physician despite at least a 3-month trial of conservative measures such as:

5. Analgesic (non-steroidal anti-inflammatory drugs (NSAIDs) and/or muscle relaxants; supportive devices (e.g., proper bra support, wide bra straps); orthopedic or spine surgeon evaluation of spinal pain.

6. Skin problems persist as documented by the physician- breakdown/infection (intertrigo; dermatitis; eczema or hidradenitis) at the inframammary fold despite of physician supervised therapy for at least 3 months with the appropriate dermatological treatments, such as topical and /or oral antibiotics, antifungal, corticosteroids along with conservative measures(e.g., good skin hygiene, adequate nutrition).

7. For women 50 years of age or older a mammogram negative for cancer within two years of date of the planned reduction mammoplasty is required; *and*

8. The surgeon estimates that the average grams of breast tissue to be removed per breast are above 22nd percentile on the Schnur Sliding Scale (see table 1) based on the individual's body surface area(BSA) or regardless of BSA, more than 1 kg of breast tissue will be removed per breast.

9. Preoperative photographs show the presence of:
    - Significant breast hypertrophy.
    - Shoulder grooving from bra straps and/or intertrigo.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The patient's medical record must reflect the medical necessity for the care provided. These records may include, but are not limited to, records from the provider's office, hospital, nursing home, home health agency, therapies, and test reports.

We may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation must be made available to the Company upon request. Failure to produce the requested information may result in a denial for the service.

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All requests for reconstructive breast surgery and reduction mammoplasty require review and must include documentation not limited to, color photographs, a letter of medical necessity from the provider, member's medical records regarding previous treatment, and other professional provider's reports.

BODY SURFACE AREA

Table1: Weight of breast tissue removed, per breast, as a function of body surface area

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.40	324
1.41	330
1.42	335
1.43	340
1.44	350
1.45	355
1.46	360
1.47	365
1.48	375
1.49	380
1.50	385
1.51	395
1.52	400
1.53	405
1.54	415
1.55	420

Table1: Weight of breast tissue removed, per breast, as a function of body surface area

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.56	430
1.57	435
1.58	445
1.59	455
1.60	460
1.61	470
1.62	480
1.63	485
1.64	495
1.65	505
1.66	510
1.67	520
1.68	530
1.69	540
1.70	550
1.71	560
1.72	570
1.73	580
1.74	590

Table1: Weight of breast tissue removed, per breast, as a function of body surface area

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.75	600
1.76	610
1.77	620
1.78	635
1.79	645
1.80	655
1.81	665
1.82	680
1.83	690
1.84	705
1.85	715
1.86	730
1.87	740
1.88	755
1.89	770
1.90	780
1.91	795
1.92	810
1.93	825

Table1: Weight of breast tissue removed, per breast, as a function of body surface area

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.94	840
1.95	855
1.96	870
1.97	885
1.98	900
1.99	915
2.00	935
2.01	950
2.02	965
2.03	985
2.04	1000
2.05	1000
2.06	1000

- To calculate body surface area (BSA) see: BMI and BSA (Mosteller) Calculator opens a dialog; *or*

  BSA (m^2) = ([height (in) x weight (lb)]/3131)^{½} (^{½} denotes square root)

- BSA (m^2) = ([height (cm) x weight (kg)]/3600)^{½} (^{½} denotes square root)

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only.

Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

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CPT Code	Description
19318	Breast reduction

HCPCS Code	Description
N/A	

ICD-10 Codes	Description
N/A	

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DESCRIPTION OF SERVICES

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Reduction mammoplasty is a surgical procedure used to treat female breast hypertrophy (i.e., macromastia or gigantomastia). The surgery involves the excision of a portion of the breast, including the skin and underlying glandular tissue, to reduce the size, shape, and weight of mammary tissue. Macromastia is defined as a marked, abnormally excessive, pendulous enlargement of one or both breasts. This condition may result in pain of the shoulder, neck, or back, nerve compression of the arms, and recurrent intertrigo in the mammary folds.

CLINICAL EVIDENCE

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

Per DHS Medicaid and CHIP products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

SUMMARY	Version	Version Date
2024 Annual review.	A	TBD
This is a new policy bulletin.	A	8/1/2023

REFERENCES

1. Centers for Medicare & Medicaid Serviceshttps://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35001&ContrId=275;

2. Chnur PL, Hoehn JG, Ilstrup DM, et al. Reduction mammoplasty: Cosmetic or reconstructive procedure? Ann Plastic Surg. 1991;27(3):232-237

3. Juliana Hansen, MD., Shiliang Chang, MD Overview of breast reduction. UpToDate, literature review through: Feb 2023, Last update Feb 17, 2021.

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

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