


MEDICAL POLICY	Breast Surgery: Reduction Mammoplasty (All Lines of Business Except Medicare)
Effective Date: 7/1/2021	Medical Policy Number: 64
 7/1/2021	Technology Assessment Committee Approved Date: 3/06 Medical Policy Committee Approved Date: 2/97; 2/98; 4/99; 8/99; 2/2000; 2/01; 4/02; 11/03; 7/04; 9/05; 5/06; 5/08; 7/10; 10/11; 5/13; 8/14; 9/15; 5/16; 12/16; 3/18; 9/18; 11/19; 05/2020; 6/2021
Medical Officer	Date

See Policy CPT CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

All lines of business except Medicare.

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY CRITERIA

Notes:

- This policy does not address the use of reduction mammoplasty as a treatment of male gynecomastia (CPT 19300), which is addressed in the “Cosmetic and Reconstructive Surgery” medical policy.
- This policy does not address the use of reduction mammoplasty as a treatment of gender dysphoria, which is addressed in the “Gender Affirming Interventions” medical policy.
- This policy does not address reconstruction following a mastectomy, which is addressed in the “Breast Reconstruction” medical policy.

MEDICAL POLICY

**Breast Surgery:
Reduction Mammoplasty
(All Lines of Business Except
Medicare)**

Mammoplasty Related to Mastectomy or Lumpectomy

Note: The following criteria (I. and II.) for mammoplasty related to mastectomy or lumpectomy apply to the affected and/or unaffected breast.

Staged Procedure

- I. A staged reduction mammoplasty as a *preparatory first stage procedure preceding a nipple-sparing mastectomy*, may be considered **medically necessary and covered** to achieve symmetry or as deemed necessary by the provider for appropriate reconstruction.

Non-staged Procedure

- II. A non-staged reduction mammoplasty may be considered **medically necessary and covered** as a treatment related to mastectomy or deforming lumpectomy when **either** of the following criteria are met:
- A. To achieve symmetry; **or**
 - B. Reduction surgery is required to facilitate radiation therapy.

Mammoplasty to Treat Macromastia

Note: For all reduction mammoplasty requests for the treatment of macromastia, the following patient information/documentation must be submitted with the surgical request:

- History and physical with evidence of conservative treatment
 - Estimated amount of tissue to be removed
 - Bra size
 - Photographs showing macromastia and shoulder grooving
 - Height and Weight
- III. For those who are 18 years and older, reduction mammoplasty may be considered **medically necessary and covered** as a treatment of macromastia when **all** of the following criteria (A.-D.) are met:
- A. Documentation of a three-month trial of conservative management such as physical therapy, exercise, weight loss, and pain medication; **and**
 - B. Photographs must be submitted to demonstrate as clinical evidence of the medical need for reduction surgery; **and**
 - C. The clinical records indicate there is significant physiologic/symptomatology which are chronic and are refractory to conservative management which are documented by **both** of the following:

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1. Symptoms are chronic and have existed for a minimum of one year; **and**
 2. One or more of the following:
 - a. Shoulders, neck or back pain where there is high probability that the symptoms are due to macromastia; **or**
 - b. Nerve root compression where there is high probability that the symptoms are due to macromastia; **or**
 - c. Other pain syndrome due to bra straps where there is high probability that the symptoms are due to macromastia; **and**
 - D. The amount of breast tissue removed from each breast is at least the minimum in grams per breast for the patient's body surface area* (see below for body surface area/breast weight table). In the case of significant breast asymmetry, the combined total in grams must meet Schnur criteria for total grams of breast tissue removed.
- IV. For those who are less than 18 years of age, reduction mammoplasty may be considered **medically necessary and covered** as a treatment of macromastia when **all** of the following criteria (A. – C.) are met:
- A. Criteria III (A. – D.) above are met; **and**
 - B. Documentation of stability of breast size for at least one year; **and**
 - C. Completion of puberty changes.
- V. Reduction mammoplasty be considered **medically necessary and covered** as a treatment of unilateral hypertrophy/macromastia.

Non-Covered Indications

- VI. Reduction mammoplasty is considered **cosmetic and is not covered** when any of the criteria I.-IV. above are not met.

***Body Surface Area Calculations**

The estimate of amount of tissue to be removed must satisfy the minimum amounts of the Schnur criteria per breast as determined by body surface area.^{1,2}

*Body surface area is calculated using the following formula:

$$\text{Take the square root of: } \frac{\text{Ht. (inches)} \times \text{Wt. (lbs)}}{3,131} = \text{BSA m}^2$$

Body surface area (m²) and cutoff weight of breast tissue removed:

Body Surface Area m ²	Minimum Breast Tissue to be removed in grams per breast	Body Surface Area m ²	Minimum Breast Tissue to be removed in grams per breast
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1.35	199	2.35	1167
1.40	218	2.40	1275
1.45	238	2.45	1393
1.50	260	2.50	1522
1.55	284	2.55	1662
1.60	310	2.60	1806
1.65	338	2.65	1972
1.70	370	2.70	2154
1.75	404	2.75	2352
1.80	441	2.80	2568
1.85	482	2.85	2804
1.90	527	2.90	3061
1.95	575	3.00	3343
2.00	628	3.05	3650
2.05	687	3.10	3985
2.10	750	3.15	4351
2.15	819	3.20	4750
2.20	895	3.25	5186
2.25	978	3.30	5663
2.30	1068	3.35	6182

Link to [Policy Summary](#)

CPT CODES

All Lines of Business except Medicare	
Prior Authorization Required	
19318	Reduction mammoplasty

DESCRIPTION

Coverage of reduction mammoplasty related to mastectomy due to suspected or confirmed malignancy is governed by the Women's Health and Cancer Rights Act of 1998 (WHCRA) in addition to applicable state and federal regulations.³⁻⁵

The medical necessity criteria within this policy that address mammoplasty related to mastectomy or lumpectomy are primarily based on the Women's Health and Cancer Rights Act (WHCRA) of 1998. The WHCRA requires all insurance carriers that cover mastectomies to also cover the following in consultation with the attending physician and patient:³

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“All stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.”³

The WHCRA law is not limited to cancer patients or women and applies to anyone who has had a mastectomy. Coverage for the surgical reduction of very large breasts (macromastia) is provided to relieve significant pain in the shoulders, neck and back. It is not covered for appearance improvement, breast ptosis, better fitting clothing or any other cosmetic reason.

Normal physiology promotes deposition of fat within the mammary structure. Any degree of obesity may be associated with disproportionate increase in breast size. Attainment of ideal body weight should be attempted prior to consideration of surgical intervention.

CLINICAL PRACTICE GUIDELINES

American Society of Plastic Surgeons (ASPS)

In 2011, the ASPS published clinical practice guidelines for reduction mammoplasty.^{6,7} The ASPS defines symptomatic breast hypertrophy as:

“a syndrome of persistent neck and shoulder pain, painful shoulder grooving from brassiere straps, chronic intertriginous rash of the inframammary fold, and/or frequent episodes of headache, backache, and upper extremity peripheral neuropathies caused by an increase in the volume and weight of breast tissue beyond normal proportions.”

The ASPS indicated that reduction mammoplasty is effective in reducing breast-related symptoms in patients with symptomatic breast hypertrophy. This was a strong recommendation; based on level I evidence (high-quality, multicenter or single-center, randomized controlled trials with adequate power; or systematic review of these studies).

The ASPS also indicated volume of breast tissue resection is not correlated to the degree of postoperative symptom relief and therefore should not be criteria for reduction mammoplasty. This was not a strong recommendation. Furthermore, if at least two out of seven breast-related physical symptoms are present all or most of the time, reduction mammoplasty is appropriate. However, these statements are primarily based on observational studies which lack randomized control groups and have a potential for selection bias.

American College of Obstetricians and Gynecologists (ACOG)

The ACOG published a consensus based expert Committee Opinion in 2017 (reaffirmed 2020) regarding adolescent breast and labial surgery.⁸ The recommendations include providing extensive patient

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education regarding nonsurgical alternatives, reassurance regarding normal variation in anatomy, growth, and development, screening for body dysmorphic disorder, and assessing the adolescent’s physical maturity and emotional readiness before surgical management or referral. The discussion section on breast reduction surgery notes that, “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.” The authors also state there is “no one consensus on timing”, and reiterate the need for the surgeon’s assessment of the adolescent’s total physical and emotional state.

POLICY SUMMARY

Reduction mammoplasty related to mastectomy due to suspected or confirmed malignancy is governed by the Women's Health and Cancer Rights Act of 1998 (WHCRA) in addition to applicable state and federal regulations. For that reason, medical necessity criteria are primarily based on the Women’s Health and Cancer Rights Act (WHCRA) of 1998. This law is not limited to cancer patients or women and applies to anyone who has had a mastectomy. The surgical reduction of very large breasts (macromastia) is provided to relieve significant pain in the shoulders, neck and back. It is not covered for appearance improvement, breast ptosis, better fitting clothing or any other cosmetic reason.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

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MEDICAL POLICY CROSS REFERENCES

- Breast Reconstruction
- Breast Surgery: Reduction Mammoplasty (Medicare Only)
- Cosmetic and Reconstructive Surgery
- Gender Affirming Interventions

REFERENCES

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8. American College of Obstetricians and Gynecologists. Committee Opinion. Number 686. January 2017 (Replaces Committee Opinion Number 662, May 2016). Committee on Adolescent Health Care. Breast and Labial Surgery in Adolescents. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/01/breast-and-labial-surgery-in-adolescents.pdf>. Published 2017 (reaffirmed 2020). Accessed 4/21/2021.