Medical Policy:

Breast Reduction Mammoplasty

POLICY NUMBER	LAST REVIEW
MG.MM.SU.01fC3	April 12, 2024

The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as "EmblemHealth"), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

Cosmetic surgery	Performed to reshape normal structures of the body to improve the patient's appearance and self-esteem.
Mastopexy	Plastic surgery to move sagging breasts into a more elevated position. It involves the repositioning of the nipple and areola and is sometimes performed in conjunction with implant insertion.
Reconstructive surgery	Performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection tumors or disease. It is generally performed to improve function but may also be done to approximate a normal appearance (e.g., following a mastectomy for breast cancer).

Related Medical Guidelines

Cosmetic and Reconstructive Surgery Procedures

Gender Affirming Surgery

Guideline

Members are eligible for breast reduction mammoplasty.

For Plan consideration, breast photographs must be submitted for review; these must include unobstructed frontal and lateral views, shoulder to waist.

For women ≥ 40, or younger if there is a positive family history (first degree relatives only) of breast cancer, documentation must also include a mammogram negative for cancer within the last 2 years of the scheduled surgery date.

Reduction mammoplasty is approved for the achievement of symmetry of the non-cancerous breast to the reconstructed breast after breast cancer surgery, regardless of the size of the unaffected breast. (Note: In certain women with macromastia and/or breast ptosis that are planned for nipple sparing mastectomy for a genetic mutation [such as BRCA1 or 2, etc.] and/or an elevated risk of breast cancer, it is medically necessary to perform a preparatory mastopexy or reduction mammaplasty prior to the mastectomy)

All of the following criteria must be met:

1. Age ≥ 18 and completed pubertal and skeletal development
2. Presence of clinically significant and persistent symptoms that have caused functional impairment for ≥ 1 year

   Symptoms and objective findings must be documented by the physician in the progress notes as directly related to macromastia and include **any** of the following:

   - History of severe intertriginous dermatitis unresponsive to medical management
   - Presence of thoracic or cervical pain syndrome (e.g., upper back, neck, or shoulder pain [excluding lower back pain]), that is not related to causes other than excessive breast weight. The syndrome should be unresponsive to conservative treatment, including both analgesia and nonsteroidal anti-inflammatory medications
   - Presence of ulnar nerve compression with documented paresthesia secondary to coracoid process descent
   - Presence of dorsal kyphosis or compensatory lordosis documented by X-rays
3. The minimum amount of breast tissue to be removed must be proportional to the body surface area (BSA)* per the Schnur scale in the table below with the estimate provided at time of pre-service review.

BSA	Grams of tissue to be removed per breast	BSA	Grams of tissue to be removed per breast
1.40–1.50	218–260	1.91–2.00	528–628
1.51–1.60	261–310	2.01–2.10	629–750
1.61–1.70	311–370	2.11–2.20	751–895
1.71–1.80	371–441	2.21–2.30	896–1068
1.81–1.90	442–527	2.31–2.40	1069–1275

* BSA (m2) = ([height (cm) x weight (kg)]/ 3600)^{½}; BSA calculator may be found at http://www.calculatorpro.com/body-surface-area-calculator

Limitations/Exclusions

- Breast reduction mammoplasty is not medically appropriate for any of the following:
  - Claims of inability to exercise
  - Fibrocystic disease
  - Improperly fitting clothing
  - Psychological or social reasons
  - Any other solely cosmetic reason to improve appearance (e.g., breast asymmetry for a member who does not meet the above criteria)
- Mastopexy is covered when associated with a reconstructive procedure

Procedure Codes

19316	Mastopexy
19318	Breast mammaplasty

ICD-10 Diagnoses

N62	Hypertrophy of breast

References

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third Party Payers: Reduction Mammaplasty. March 2021. http://www.plasticsurgery.org/for-medical-professionals/legislation-and-advocacy/health-policy-resources/recommended-insurance-coverage-criteria.html. Accessed April 22, 2024.

Antoniuk PM. Breast augmentation and breast reduction. *Obstet Gynecol Clin North Am*. 2002;29:103-115.

Behmand RA, Tang DH, Smith DJ Jr. Outcomes in breast reduction surgery. *Ann Plast Surg*. 2000;45:575-580.

Chadbourne, EB, Zhang S, Gordon MJ, et al. Clinical outcomes in reduction mammoplasty: a systemic review and metaanalysis of published studies. *Mayo Clin Proc*. 2001;76:503-510.

Collins ED, Kerrigan CL, Kim M, et al. The effectiveness of surgical and non-surgical interventions in relieving the symptoms of macromastia. *Plast Reconstr Surg*. 2002;109:1556-1566.

Kerrigan CL, Collins ED, Kim HM, et al. Reduction mammaplasty: defining medical necessity. *Med Decis Making*. 2002;22:208-217.

Kerrigan CL, Collins ED, Striplin D, et al. The health burden of breast hypertrophy. *Plast Reconstr Surg*. 2001;108:1591-1599

Makki AS, Ghanem AA. Long term results and patient satisfaction with reduction mammaplasty. *Ann Plast Surg*. 1998;41:370-377.

Mizgala CL, MacKenzia KM. Breast reduction outcome study. *Ann Plast Surg*. 2000;44:125-134.

Raispis T, Zehring RD, Downey DL. Long-term functional results after reduction mammoplasty. *Ann Plast Surg*. 1995;34:113-116.

Schnur PL, Hoehn JG, Ilstrup DM, et al. Reduction mammoplasty: cosmetic or reconstructive procedure? *Ann Plast Surg*. 1991;27:232-237.

Schnur PL, Schnur DP, Petty PM, et al. Reduction mammaplasty: an outcome study. *Plast Reconstr Surg*. 1997;100:875-883.

Specialty-matched clinical peer review.

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	Mar.27, 2024	Added note RE the medical necessity of preparatory mastopexy or reduction mammaplasty prior to the mastectomy
EmblemHealth ConnectiCare	Feb. 9, 2024	RE intertriginous dermatitis, replaced “Presence” of with “History”, and removed language pertaining to photos
ConnectiCare	Jul. 15, 2021	Retired MCG criteria for this service Adopted the clinical criteria of parent corporation EmblemHealth
EmblemHealth	Jul. 9, 2021	Amended Schnur scale note by adding that the “minimum” amount of breast tissue to be removed must be proportional to the body surface area (BSA)