Reduction Mammaplasty

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon* ☐ *Washington*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Female breast hypertrophy, or macromastia, is the development of abnormally large breasts. 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 distinguished from large, normal breasts by the presence of persistent symptoms such as shoulder, neck, or back pain, shoulder grooving, or intertrigo. Although usually seen as symmetric involvement of both breasts, unilateral hypertrophy occasionally occurs. Breast hypertrophy may also become symptomatic after mastectomy of the opposite breast.

Reduction mammaplasty is the surgical excision of a substantial portion of the breast, including the skin and underlying glandular tissue to alleviate symptoms of macromastia. Medical necessity is based on the documented symptoms and the requisite grams of tissue to be removed as represented by the physician. PacificSource uses the Mosteller formula to calculate body surface area (BSA) and the Schnur Sliding Scale for calculation of breast tissue removed. See definitions for links and formulas.

Male breast enlargement, referred to as Gynecomastia, is mainly due to excessive growth of benign glandular tissue.

Criteria

Commercial

Prior authorization is required

I. Reduction Mammaplasty

A. PacificSource considers mastectomy for gynecomastia to be medically necessary when MCG criteria ACG:A-0273 (AC) is met.

B. PacificSource considers Reduction Mammaplasty to be medically necessary when **ALL** of the following criteria is met:

1. Female age 18 years or older

2. History of **two or more** of the following signs and symptoms:

a. Must meet both of the following:

1. Diagnosis of one of the following
- chronic pain in the upper back, neck, and/or shoulders that is not associated with another diagnosis (e.g., arthritis),
- chronic breast pain due to weight of breasts

2. Pain has not improved with conservative measures (e.g., appropriate support bra, exercise/physical therapy, heat/cold treatment, appropriate anti-inflammatory agents/muscle relaxants)

b. Ulceration of skin on shoulder or shoulder grooving and/or persistent intertrigo between the pendulous breast and the chest wall not responding to conservative treatment, including dermatological therapy

c. Neurological symptoms related to brachial plexus pressure

d. Thoracic kyphosis documented by x-ray

e. Occipital headache that is not attributable to other factors or conditions

3. Minimum breast tissue to be removed is determined by Schnur Sliding Scale calculation (see definition below), which cannot be less than 350 grams per breast.

Exclusions

Reduction mammaplasty procedures that do not meet the above criteria are considered not medically necessary.

The use of liposuction as an additional procedure with mammaplasty reduction is considered not medically necessary.

Medicaid

PacificSource Community Solutions follows Oregon Administrative Rules (OARs) 410-120-1200, 410-141-3820 through 3825, 410-151-0000 through 0003, and Guideline Notes 79, 127, 166, and 196 of the OHP Prioritized List of Health Services for coverage of Reduction Mammaplasty.

PacificSource Community Solutions follows the hierarchal process in the “Clinical Criteria Used in UM Decisions” policy for coverage of reduction mammaplasties and mastectomies for gynecomastia. PCS covers these services when the condition and service(s) pair on a funded line on the HERC Prioritized List of Health Services, any relevant Guideline criteria is fulfilled, and service(s) are medically/orally necessary and appropriate for the specific member. Additional coverage options for unfunded conditions and services are provided as described in Covered Services OAR 410-141-3820. Service(s)

may be limited or excluded in accordance with OARs 410-141-3825 and 410-120-1200, except as otherwise provided in the Covered Services Rule.

PacificSource follows the “Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)” criteria for members under 21 and Young Adults with Special Health Care Needs (YSHCN).

PCS follows the “Gender Affirming Surgery and Related Procedures” policy for Mammaplasties performed as part of gender affirming treatment.

Medicare

PacificSource Medicare uses National Coverage Determination (NCD) 140.2 and Local Coverage Determination (LCD) L37020 for Breast Reconstruction Following Mastectomy and Plastic Surgery.

PacificSource Medicare follows CMS guidelines and criteria for mastectomies to treat gynecomastia. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

Experimental/Investigational/Unproven

PacificSource considers the use of liposuction as the sole procedure for breast reduction to be experimental/investigational and/or unproven.

Coding Information

19300 Mastectomy for gynecomastia

19318 Reduction mammaplasty

Definitions

Cosmetic procedures – procedures to improve the body’s appearance and not primarily to restore impaired function of the body.

Gynecomastia - enlargement of the male breast, mainly due to excessive growth of glandular tissue.

Intractable - the presence of symptoms for at least one year despite the use of conservative treatments.

Mastectomy for Gynecomastia - Surgery to remove excessive breast tissue (mastectomy) when a man has overly enlarged breasts (gynecomastia).

Macromastia (mammary hyperplasia) - the development of abnormally large breasts. Macromastia that requires surgical intervention is distinguished from large, normal breasts by the presence of persistent, painful symptoms and physical signs.

Mosteller Formula – to measure body surface area; (m^2) = ([height (cm) x weight (kg)] / 3600)½ [1] To calculate BSA, use the online calculator at http://www.halls.md/body-surface-area/bsa.htm, **or** use one of the following equations:

Square root of [(height in inches) x (weight in pounds)]/3131 = BSA (m^2)

Square root of ([(height in centimeters) x (weight in kilograms)] / 3600) = BSA (m^2)

Reduction Mammaplasty (also spelled mammaplasty) - surgical excision of a portion of the breast, including skin and underlying glandular tissue with repositioning of the areola and nipple.

SCHNUR SLIDING SCALE (MODIFIED): uses body surface area (BSA) in square meters to calculate the minimum tissue removal expected that would reflect a true medical indication for reduction mammaplasty.

SCHNUR SLIDING SCALE

Body Surface Area	Grams per Breast of Minimum Breast Tissue to be Removed
1.350-1.374	199
1.375-1.399	208
1.400-1.424	218
1.425-1.449	227
1.450-1.474	238
1.475-1.499	249
1.500-1.524	260
1.525-1.549	272
1.550-1.574	284
1.575-1.599	297
1.600-1.624	310
1.625-1.649	324
1.650 -1.674	338
1.675 -1.699	354
1.700 -1.724	370
1.725 -1.749	386
1.750 -1.774	404
1.775 -1.799	422
1.800 -1.824	441
1.825 -1.849	461
1.850 -1.874	482
1.875 -1.899	504
1.900 -1.924	527
1.925 -1.949	550
1.950 -1.974	575
1.975 -1.999	601
2.000 -2.024	628
2.025 -2.049	657
2.050 -2.074	687
2.075 -2.099	717
2.100 -2.124	750
2.125 -2.149	784
2.150 -2.174	819
2.175 -2.199	856
2.200 -2.224	895
2.225 -2.249	935
2.250 -2.274	978
2.275 -2.299	1022
2.300 -2.324	1068
2.325 -2.349	1117
2.350 -2.374	1167
2.375 -2.399	1219
2.400 -2.424	1275
2.425 -2.449	1333
2.450 -2.474	1393
2.475 -2.499	1455
2.500-2.524	1522

2.525 -2.549	1590
2.550 or greater	1662

Note: When BSA is < 1.350, minimum tissue removal is 199 grams.

Related Policies

Care of the Surgical Patient

Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Gender Affirming Surgery and Related Procedures

References

American Society of Plastic Surgeons. (May 2011). Reduction Mammaplasty Recommended Criteria for Third-Party Payer Coverage from the American Society of Plastic Surgeons (ASPS).

Center of Medicare and Medicaid (CMS). (March 9, 2023). Medicare National Coverage Determinations (NCD) Manual, Part 2: Section 140.2: Breast Reconstruction Following Mastectomy.

Kalliainen, L. K., & ASPS Health Policy Committee (2012). ASPS clinical practice guideline summary on reduction mammaplasty. Plastic and reconstructive surgery, 130(4), 785–789.

MCG™, Ambulatory Care, Reduction Mammaplasty (Mammoplasty) ACG: A-0274 (AC).

Perdikis, G., Dillingham, C., Boukovalas, S., Ogunleye, A. A., Casambre, F., Dal Cin, A., Davidson, C., Davies, C. C., Donnelly, K. C., Fischer, J. P., Johnson, D. J., Labow, B. I., Maasarani, S., Mullen, K., Reiland, J., Rohde, C., Slezak, S., Taylor, A., Visvabharathy, V., & Yoon-Schwartz, D. (2022). American Society of Plastic Surgeons Evidence-Based Clinical Practice Guideline Revision: Reduction Mammaplasty. Plastic and reconstructive surgery, 149(3), 392e–409e. https://pubmed.ncbi.nlm.nih.gov/35006204/

The Health Evidence Review Commission (HERC) Prioritized List of Health Services https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Medical Assistance Programs – Chapter 410 https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87

Appendix

Policy Number:

Effective: 7/1/2020 **Next review:** 7/1/2026

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): NCD 140.2, LCD L37020, OARs 410-120-1200, 410-141-3820,410-141-3825, 410-151-0000 through 0003

Commercial OPs: 6/2025