



Reduction Mammoplasty

State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:	LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid
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Enterprise Policy

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 determination 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

Breast reconstruction following medically necessary mastectomy, including reconstruction of the opposite breast to achieve cosmetic symmetry, is a covered benefit. See PacificSource Preauthorization and Coverage of Post Mastectomy Related Services Policy.

Breast surgery for males of all ages is subject to preauthorization. See MCG Mastectomy for Gynecomastia A-0273 (AC) for criteria.

Gender affirming mammoplasty or mastectomy procedures are subject to preauthorization. See the PacificSource Gender Affirming Surgery and Related Procedures policy for criteria.

Criteria

Commercial

Reduction mammoplasty is considered medically necessary and not cosmetic when **ALL** of the following clinical indications and physical findings are present. Preauthorization is required.

- Female age 18 years or older
- History of two or more of the following intractable signs and symptoms:
 - Pain in the upper back, neck, and/or shoulders that is not associated with another diagnosis (e.g. arthritis), and not improved with conservative measures (e.g., appropriate support bra, exercise/physical therapy, heat/cold treatment, appropriate anti-inflammatory agents/muscle relaxants).

- Chronic breast pain due to weight of breasts not improved with conservative measures (e.g., appropriate support bra, exercise/physical therapy, heat/cold treatment, appropriate anti-inflammatory agents/muscle relaxants).
- 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-
- Neurological symptoms related to brachial plexus pressure.
- Thoracic kyphosis documented by x-ray-
- Occipital headache that is not attributable to other factors or conditions-
- Breast tissue removal requirements:
 - At least 350 grams from each breast; **and**
 - Additional grams, if required per Schnur Sliding Scale calculation

The Schnur Sliding Scale uses body surface area (BSA) in square meters to calculate the minimum tissue removal expected that would reflect a true medical indication for reduction mammoplasty (See Appendix A).

PacificSource uses the Mosteller formula to calculate BSA.

To calculate BSA, reference <http://www.halls.md/body-surface-area/bsa.htm> for an online calculator, **OR**

Use the equation: [The square root of: (height in inches) x (weight in pounds)] = BSA m²

- UM Clinicians can approve up to a 100 gram variance (less than required by Schnur Scale) per breast

Claim submission requirements

Medical necessity is based on the documented symptoms and the requisite grams of tissue to be removed as represented by the physician. Please include the pathology report with the claim to verify. Reduction mammoplasty not completed within 90 days of authorization is subject to a repeat medical review and preauthorization.

Cosmetic Procedures

Reduction mammoplasty procedures that do not meet the above criteria are considered cosmetic and are not covered. Cosmetic procedures are those performed to improve the body's appearance and not primarily to restore impaired function of the body.

Medicare

PacificSource Medicare does not require prior authorization. For reviews of medical necessity, Local Coverage Determination (LCD) L35163 is utilized for services provided within our coverage areas (ID, MT, OR, WA).

Medicaid

PacificSource Medicaid does not follow this policy but follows the guidance of Guideline Notes 79, 127, 166, and 196 of the OHP Prioritized List of Health Services.

Coding Information

19318 Unilateral reduction mammoplasty

19318-50 Opposite breast reduction mammoplasty

Definitions

Intractable is defined as the presence of symptoms for at least one year despite the use of conservative treatments.

Macromastia (mammary hyperplasia) is 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.

Reduction Mammoplasty is surgical excision of mammary tissue and repositioning of the areola and nipple.

Related PacificSource policies

Gender Affirming Surgery and Related Procedures policy

Preauthorization and Coverage of Post Mastectomy Related Services

References

MCG™ 24th edition, Ambulatory Care, Reduction Mammoplasty (Mammoplasty) ACG: A-0274 (AC).

Medline Plus: Cosmetic Breast Surgery, Updated 02/12/2013 by David A. Lickstein, MD, FACS, specializing in cosmetic and reconstructive plastic surgery, Palm Beach Gardens, FL.

UpToDate. Hansen, Julianna, Overview of breast reduction. January 14, 2020.

<https://www.uptodate.com/contents/overview-of-breast-reduction>

APPENDIX A: SCHNUR SLIDING SCALE (MODIFIED):

Body Surface Area and Cutoff Weight of Breast Tissue Removed

Body Surface Area (BSA m ²)	Weight of tissue removed per breast (grams) 22nd percentile		Body Surface Area (BSA m ²)	Weight of tissue removed per breast (grams) 22nd percentile
1.35	350		2.00	628
1.40	350		2.05	687

1.45	350		2.10	750
1.50	350		2.15	819
1.55	350		2.20	895
1.60	350		2.25	978
1.65	350		2.30	1,068
1.70	370		2.35	1,167
1.75	404		2.40	1,275
1.80	441		2.45	1,393
1.85	482		2.50	1,522
1.90	527		2.55	1,662
1.95	575			

Appendix

Policy Number: [Policy Number]

Effective: 7/1/2020

Next review: 7/1/2021

Policy type: Enterprise

Depts: Health Services

Applicable regulation(s): N/A

External entities affected: N/A