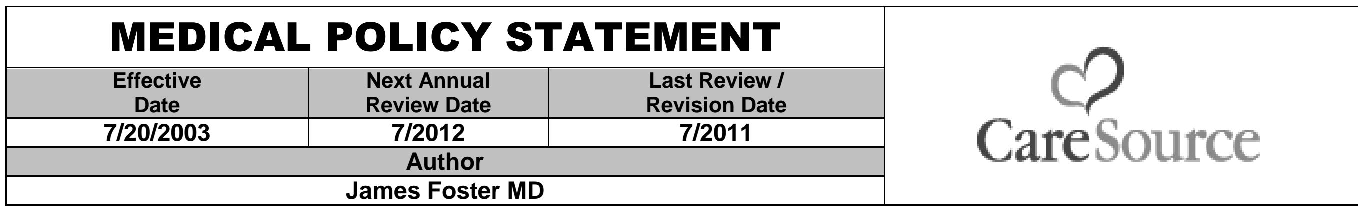

MEDICAL POLICY STATEMENT		
Effective Date	Next Annual Review Date	Last Review / Revision Date
7/20/2003	7/2012	7/2011
Author		
James Foster MD		

CareSource

CSMG Medical Policy Statements are derived from literature based and supported clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services are those health care services or supplies which are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative and are not provided mainly for the convenience of the member or provider.

A. SUBJECT

Breast Reduction

B. BACKGROUND

This document is to establish a medical policy concerning breast reduction surgery.

C. POLICY

For Special Needs Plan members, reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

CareSource considers breast reduction surgery medically necessary when breast hypertrophy is causing significant pain, paresthesias, or ulceration (see selection criteria below). Reduction mammoplasty for asymptomatic members is considered cosmetic. Please check benefit plan descriptions for details.

CareSource considers breast reduction surgery medically necessary for non-cosmetic indications for women age 18 or older or for whom growth is complete when ***any*** of the following criteria (A or B) is met:

A. Macromastia: ***all*** of the following criteria must be directly attributable to the macromastia and must be met:

1. Member has persistent symptoms in at least two (2) of the anatomical body areas below, affecting daily activities for at least one year documented in the office notes over that period of time:

- Pain in upper back
- Pain in neck
- Pain in shoulders
- Paresthesia of hands and/or arms
- Headaches
- Painful kyphosis documented by X-rays

- Pain / discomfort / shoulder grooving / ulceration from bra straps cutting into shoulders

2. Estimated breast tissue to be removed per breast must be greater than 500 gm.

3. Must have a BMI of 35 or below for a minimum of 90 days prior to the request.

B. Asymmetry:

For medical necessity, criteria for surgery to correct breast asymmetry; see breast reconstructive surgery policy.

For Medicare LCD Number L30733

Local Coverage Determination for Cosmetic and Reconstructive Surgery (L30733)

D. REVIEW / REVISION HISTORY

Date Issued: 7/20/2004
Date Revised: 5/25/2005, 7/5/2006, 9/18/2007, 7/1/2009
Date Reviewed: 7/1/2009, 7/2011

E. REFERENCES

1. Howrigan P. Reduction and augmentation mammoplasty. Obstet Gynecol Clin North Am. 1994;21(3):539-543.

2. Miller AP, Zacher JB, Berggren RB, et al. Breast reduction for symptomatic macromastia. Can objective predictors for operative success be identified? Plastic Reconstruct Surg. 1995;95(1):77-83.

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

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.