MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
07/20/2003	12/31/2016	12/01/2015

Policy Name	Policy Number
Breast Reduction Surgery	**MM-0020**

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that 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. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT

Breast Reduction Surgery

B. BACKGROUND

Macromastia is the development of abnormally large breasts in the member as a result of breast hypertrophy. This condition can cause a variety of clinical manifestations when the weight of the excessive breast tissue adversely impacts supporting structures of the shoulders, neck and trunk. Macromastia is distinguished from large, normal breasts by the presence of persistent symptoms.

Reduction mammoplasty is the surgical removal of breast tissue, including the skin and the underlying glandular tissue, to approximate a more clinically normal size and reduce clinical symptoms. For the purpose of this policy, macromastia is considered the primary cause for the signs, symptoms and functional impairment being described.

The Schnur Sliding Scale is an evaluation tool used to determine the appropriate volume of tissue to be removed relative to a patient's total body surface area (BSA). This estimation can be instrumental in determining whether breast reduction surgery is being planned for cosmetic reasons or as a medically necessary procedure. In a survey of plastic surgeons utilizing this scale, Schnur et al. (1991) determined that a member whose removed breast weight was above the 22nd percentile were likely to receive the procedure for medical reasons.

C. DEFINITIONS

N/A

D. POLICY

I. CareSource considers breast reduction surgery medically necessary for non-cosmetic indications for members age 18 or older, or for whom growth is complete, when **ALL** of the following criteria are met:

A. Member has signs and/or symptoms lasting for at least one year, documented in contemporaneous notes from the treating physician which are:

1. Attributable to macromastia; having excluded other causes through a reasonable clinical evaluation
   AND
2. Involved **2 (two) or more** of the following anatomical areas:
   2.1 Pain in upper back
   2.2 Pain in neck or shoulders
   2.3 Paresthesia of hands and/or arms
   2.4 Headaches
   2.5 Kyphosis documented by X-rays
   2.6 Skin manifestations documented by photographs (including intertrigo, exacerbation of acne or hidradenitis suppurativa)
   2.7 Shoulder grooving or ulceration from bra straps cutting into the shoulders documented by photographs

B. Are associated with described functional impairment(s) affecting daily living for at least one year

C. Which have not responded to a recent 3 month physician supervised course of conservative therapy, including (but not limited to) a combination of weight loss, appropriate bra support (i.e. properly fitting with wide straps), physical therapy, and/or home exercise program, appropriate medications (including NSAID and/or analgesic agents) and appropriate treatment of associated skin conditions

II. Physician documentation must include **ALL** of the following:

A. Contemporaneous progress notes outlining the above criteria (1.b. I-VII)
B. Photographic documentation (including skin manifestations, if any)
C. The member's bra size, height and weight
D. An estimation of the volume of breast tissue to be removed

The weight of tissue to be removed from each breast must be above the 22nd percentile on the Schnur Sliding Scale (Appendix A below) based on the individual's body surface area (BSA).

The body surface area in meters squared (m2) is calculated using the Mosteller formula as follows:

$$\text{Square root of: } \frac{\text{Ht. (inches) x Wt. (lbs).}}{3{,}131}$$

III. **Mammography:** Members 40 years of age or older must have documentation of a mammogram negative for cancer performed within the year prior to the date of the planned breast reduction surgery.

IV. **Liposuction:** The use of liposuction, either entirely or adjunctively for the purpose of breast reduction is considered medically unnecessary.

V. **Surgery for Gynecomastia:** For medical necessity and criteria for surgery of gynecomastia see CareSource Medical Policy statement for "Mastectomy for Gynecomastia".

VI. **Breast Asymmetry:** For medical necessity and criteria for surgery to correct breast asymmetry see CareSource Medical Policy statement for “Breast Reconstructive Surgery”.

Appendix A: **Schnur Sliding Scale**

Body Surface Area and Minimum Requirement for Breast Tissue Removal	
Body Surface Area m^2	**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

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

For Medicare NCD: CMS Publication 100-3, Medicare National Coverage Determinations, Chapter 1, Section 140.2
https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf

If there is no NCD or LCD present, reference the CareSource Policy for coverage.

CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	07/20/2004
Date Reviewed:	07/20/2004, 05/25/2005, 07/5/2006, 09/18/2007, 07/01/2009, 02/2012, 12/31/2014, 12/01/2015
Date Revised:	07/1/2009, 07/2011, 02/2012, 07/2013, 12/31/2014

G. REFERENCES

1. Howrigan P. Reducution and augmentation mammpoplasty. 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.
4. Mosteller RD: Simplified Calculation of Body Surface Area. *N Engl J Med* 1987 Oct 22; 317(17):1098 (letter).
5. Milliman, 19th Edition, 2015.

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

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