MEDICAL POLICY STATEMENT
Kentucky Marketplace

Policy Name & Number	Date Effective
Breast Reduction Surgery-KY MP-MM-0249	06/01/2022
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Breast Reduction Surgery

B. Background

Women who suffer from macromastia seeking breast reduction typically present with complaints of a feeling of heaviness, chronic pain and tension in the neck, shoulders and upper back. Macromastia commonly causes permanent grooving and ulceration of the shoulder following years of wearing support bras to try to minimize symptoms. As much as two to five pounds of excess breast tissue is routinely removed during a reduction mammoplasty.

Reduction mammoplasty is a surgical procedure, reducing the weight and volume of the breast. Indications for surgery include chronic pain and skin conditions, neuropathy, breast discomfort, physical impairment and psychological symptoms that can be associated with poor self-esteem and loss of desire to engage in activities.

C. Definitions

- **Cellulitis** - An acute spreading bacterial infection in the deeper layers of skin associated with an abrasion or cut and characterized by redness, warmth and swelling.
- **Cosmetic Procedures** - Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures.
- **Functional/Physical or Physiological Impairment** - Physical/functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired or delayed capacity to move and coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks, independent movement, performing basic life functions.
- **Intertriginous Rash** - Dermatitis occurring between juxtaposed folds of skin, caused by retention of moisture and warmth and providing an environment favoring overgrowth of normal skin micro-organisms.
- **Kyphosis** - Over-curvature of the thoracic vertebrae (upper back) associated with: degenerative diseases such as arthritis, developmental problems, or with osteoporotic compression fractures of vertebral bodies.
- **Macromastia (Breast Hypertrophy)** - An increase in the volume and weight of breast tissue relative to the general body habitus.
- **Symptomatic Breast Hypertrophy** - A syndrome of persistent neck and shoulder pain, shoulder grooving from brassiere straps, chronic intertriginous rash of the infra-mammary fold and/or frequent episodes of headache, backache, and upper extremity neuropathies caused by an increase in the volume and weight of breast tissue beyond normal proportions.
- **The Schnur Sliding Scale** - Has been promoted for use in calculating the amount of breast tissue to be removed in reduction mammoplasty (Appendix A).

D. Policy

I. CareSource considers breast reduction surgery for non-cosmetic reasons medically necessary when ALL of the following clinical criteria are met:
   A. Member must be eighteen (18) years or older, or growth is complete.
   B. *Breast size interferes with activities of daily living, as indicated by 1 or more of the following:*
      1. *Arm numbness consistent with brachial plexus compression syndrome,*
      2. *Cervical pain,*
      3. *Chronic breast pain,*
      4. *Headaches,*
      5. *Nipple position greater than 21 cm below suprasternal notch,*
      6. *Persistent redness and erythema (intertrigo) below breasts,*
      7. *Restriction of physical activity,*
      8. *Severe bra strap grooving or ulceration of shoulder,*
      9. *Shoulder pain,*
      10. *Thoracic kyphosis, or*
      11. *Upper or lower back pain.*
   C. *Failure to relieve symptoms with nonsurgical treatment that includes 1 or more of the following:*
      1. *Medically supervised weight loss program for overweight or obese patient,*
      2. *Topical and oral antifungal agents for intertrigo,*
      3. *Trial of nonsteroidal anti-inflammatory drugs to treat pain in neck, shoulder, upper or lower back, or breast, or*
      4. *Wound care for skin ulceration.*
   D. *Preoperative evaluation by surgeon concludes that amount of breast tissue to be removed (by mass or volume) will provide a reasonable expectation of symptomatic relief.*
   E. *No evidence of breast cancer*
      1. As evidenced by results of a physical exam completed by a physician within the last year if under 40 years of age.
      2. Women 40 to 54 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.
      3. Women 55 years of age and older may switch to mammograms every 2 years.

II. Breast reduction surgery following mastectomy to achieve symmetry is covered as part of the *Women's Health and Cancer Rights Act (WHCRA).* Please refer to the CareSource Medical policy titled *Breast Reconstruction Post Mastectomy* for additional information.

III. Schnur Sliding Scale
   A. 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).
      1. 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.

2. 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).
3. The body surface area in meters squared (m^2) is calculated using the Mosteller formula as follows:
   a. Square root of height (inches) x weight (lbs) divided by 3131.

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

E. Conditions of Coverage

NA

F. Related Policies/Rules

Breast Reconstruction Surgery MM-0801

G. Review/Revision History

	DATE	ACTION
Date Issued	10/01/2018	
Date Revised	04/15/2020	Annual Update: Update to MCG Health 23rd Edition Clinical Indications; addition of Related Policies.

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

	03/16/2022	No change in content. Removed related policy for Breast Asymmetry statement. Updated references. Approved at PGC.
Date Effective	06/01/2022	
Date Archived		

H. References

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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.

Independent medical review – ***March 2018***