MEDICAL POLICY STATEMENT
OHIO MARKETPLACE PLANS

Original Issue Date	Next Annual Review	Effective Date
07/20/2003	11/01/2019	11/01/2018
Policy Name		**Policy Number**
Breast Reduction Surgery		MM-0251
Policy Type		
MEDICAL	Administrative / Pharmacy	Reimbursement

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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.

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A. SUBJECT

Breast Reduction Surgery

B. BACKGROUND

Reduction mammoplasty is a surgical procedure performed to reduce the volume and weight of the female breasts. It may be performed for a variety of reasons, including relief of physical symptoms, relief of psychological symptoms, or as a cosmetic procedure based on the patient's preference for smaller breast size. Reduction Mammoplasty is among the most commonly performed cosmetic procedures in the United States. Female symptomatic breast hypertrophy can have both physical and psychosocial manifestations. In addition, some patients report impairment in lifting or participating in exercise and other physical activities. Patients may also report low self-esteem and dissatisfaction with body image. Given these consequences, female symptomatic macromastia or breast hypertrophy is recognized as a medical condition that requires treatment. Reduction Mammoplasty performed solely for cosmetic indications is considered by CareSource not to be a medically necessary treatment of disease.

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. For the purpose of this policy, macromastia is considered the primary cause for the signs, symptoms and functional impairment being described. Reduction Mammoplasty is effective in relieving the symptoms of macromastia.

C. DEFINITIONS

- **Macromastia (Breast Hypertrophy):** An increase in the volume and weight of breast tissue relative to the general body habitus.
- **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, 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.
- **Symptomatic Breast Hypertrophy:** A syndrome of persistent neck and shoulder pain, painful 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.
- **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.
- **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.
- **The Schnur Sliding Scale:** Has been promoted for use in calculating the amount of breast tissue to be removed in reduction mammoplasty (Appendix A).
- **Cosmetic Procedures:** Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure

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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 are present:*

*A. 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
11. Upper or lower back pain

*B. Failure to relieve symptoms with nonsurgical treatment that includes **1 or more** of the following:*

1. Four to eight visits of physical therapy or chiropractic care, and 2 to 4 months of home exercise for cervical, shoulder or upper or lower back pain
2. Medically supervised weight loss program for at least 3 months for overweight or obese patient
3. Topical and oral antifungal agents for intertrigo
4. Trial of nonsteroidal anti-inflammatory drugs to treat pain in neck, shoulder, upper or lower back, or breast
5. Wound care for skin ulceration
6. Appropriate bra support for at least 3 months (i.e. properly fitting with wide straps)

C. 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

1. 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).
2. 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. 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 (m2) is calculated using the Mosteller formula as follows:
   3.1 Square root of height (inches) x weight (lbs.) divided by 3,131

D. 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
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 and older may switch to mammograms every 2 years

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E. 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.

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

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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

HCPCS
CPT

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	07/20/2003	New Policy.
Date Revised	07/01/2009 07/01/2011 02/01/2012 07/01/2013 12/31/2014 12/01/2015	
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H. 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.
4. Mosteller RD: Simplified Calculation of Body Surface Area. *N Engl J Med* 1987 Oct 22; 317(17):1098 (letter).
5. American Society of Plastic Surgeons: Evidence-based Clinical Practice Guideline: Reduction Mammaplasty 2011
6. The Center for Consumer Information & Insurance Oversight; Women's Health and Cancer Rights Act (WHCRA)

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.

Independent medical review – 06/2018

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