HAP CareSource™

MEDICAL POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Breast Reduction Surgery-MI MCD-MM-1517	05/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract 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

Reduction mammaplasty is a surgical procedure that reduces the weight and volume of the breast. As much as one to five pounds of excess breast tissue is routinely removed during a reduction mammaplasty depending on breast and body mass. 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.

Women diagnosed with macromastia (excessively large breasts) seeking breast reduction mammaplasty 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. The physical and psychological symptoms of macromastia can significantly and negatively impact an individual's life and should be taken into consideration when evaluating surgical intervention.

Gynecomastia is the benign proliferation of glandular tissue of the breast in males. This condition may be caused by androgen deficiency, congenital disorders, medications, chronic medical conditions, tumors, or endocrine disorders. Depending on the cause of the tissue proliferation, surgical removal may be considered cosmetic or medically necessary.

C. Definitions

- **Body Surface Area (BSA)** – A metric used for physiologic measurements, pharmacologic dosing and therapeutic calculations, including the Schnur Sliding Scale for breast reduction surgery.
- **Cosmetic Procedures** – Procedures performed for aesthetic purposes that do not improve or restore physiologic function.
- **Functional/Physical or Physiological Impairment** – 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 physical and motor tasks, independent movement, and/or performing basic life functions.
- **Gynecomastia** – Enlargement of the male breast secondary to a proliferation of ductal, stromal, and/or fatty tissue.
- **Gynecomastia Scale** – A qualitative classification system for gynecomastia developed by the American Society of Plastic Surgeons (ASPS).
  - **Grade I** – Small breast enlargement with localized button of tissue that is concentrated around the areola.
  - **Grade II** – Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.

  - **Grade III** – Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present.
  - **Grade IV** – Marked breast enlargement with skin redundancy and feminization of the breast.
- **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.
- **Mammography** – An imaging technique that uses low-energy X-rays to examine breast tissue for diagnosis and screening.
- **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.
- **Schnur Sliding Scale** – Used in calculating the amount of breast tissue to be removed in reduction mammoplasty (Appendix A).

D. Policy

I. HAP CareSource considers breast reduction surgery for macromastia medically necessary when **ALL** the following criteria are met and have been documented:

A. Member is 18 years or older, or under 18 years with evidence that breasts have finished growing for a minimum of one year. Parental/guardian consent is required for members under age 18.

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, nonresponsive to conventional/medical management
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

C. Preoperative evaluation by surgeon concludes that the amount of breast tissue to be removed (by mass or volume) will provide a reasonable expectation of

symptomatic relief.

D. No evidence of breast cancer
   1. 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 with 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 with negative mammograms for cancer every 2 years
   4. women with family history of breast cancer with mammograms starting at least 7 years prior to when the youngest family member was diagnosed with breast cancer (as early as 30 years of age)

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 HAP CareSource Medical policy titled *Breast Reconstruction Surgery* for additional information.

III. HAP CareSource considers breast reduction surgery for gynecomastia medically necessary when **ALL** the following clinical criteria are met and have been documented:
   A. Member is 18 years or older, or under 18 years with evidence that breasts have finished growing for a minimum of 1 year. Parental/guardian consent is required for members under age 18.
   B. A physical exam has been conducted by an appropriately credentialed provider and confirms the presence of gynecomastia:
      1. pubertal male (adolescent)
         a. gynecomastia present for more than 1 year after pathological causes ruled out
         b. gynecomastia grade II, III, or IV
      2. postpubertal male
         a. gynecomastia present for more than 3 months after pathological causes ruled out
         b. gynecomastia grade III or IV
   C. The tissue being removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of drug treatment that can be discontinued.
   D. The gynecomastia is attributed to an underlying condition (not an all-inclusive list), including:
      1. androgen deficiency
      2. chronic liver disease that causes decreased androgen availability
      3. Klinefelter syndrome
      4. adrenal tumors that cause androgen deficiency or increased secretion of estrogen
      5. brain tumors that cause androgen deficiency
      6. testicular tumors that cause androgen deficiency or tumor secretion of

estrogen
7. endocrine disorders (eg, hyperthyroidism)

E. The gynecomastia causes functional impairment (eg, pain, chronic irritation)
F. Breast malignancy was ruled out.

IV. Surgical Exclusions:
A. Liposuction to perform breast reduction is considered not medically necessary.
B. CareSource does not cover:
1. any procedures that are considered experimental, investigational, or unproven.
2. breast reduction surgery performed solely for cosmetic reasons (eg, poor posture, pendulousness, breast asymmetry, fit of clothing, changes in nipple-areola appearance).

V. Schnur Sliding Scale
The Schnur Sliding Scale is one of several evaluation tools used to determine the appropriate volume of tissue to be removed relative to a member'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.
A. The weight of tissue to be removed from each breast is recommended to be above the 22nd percentile on the Schnur Sliding Scale (Appendix A below) based on the member's BSA.
B. The BSA in meters squared (m^2) is calculated using the Mosteller formula (square root of the result of height (inches) multiplied by weight (lbs.) and 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 – 22nd Percentile**
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
N/A

F. Related Policies/Rules
Breast Reconstruction Surgery

G. Review/Revision History

	DATE	ACTION
Date Issued	9/13/2023	New policy. Approved at Committee.
Date Revised	02/28/2024	Revision: removed definitions, expanded policy to cover members under 18 years of age, and updated references. Approved at Committee.
	03/12/2025	Annual review: updated background and definitions, added D.I.D.4., revised gynecomastia criteria, and updated references. Approved at Committee.
	02/11/2026	Review: added definitions, and clarity around exclusions for cosmetic indications and liposuction. Approved at Committee.
Date Effective	05/01/2026	
Date Archived		

H. References

1. ASPS recommended insurance coverage criteria for third-party payers: gynecomastia. American Society of Plastic Surgeons. Accessed January 7, 2026. www.plasticsurgery.org
2. ASPS recommended insurance coverage criteria for third-party payers: reduction mammaplasty. American Society of Plastic Surgeons. Accessed January 7, 2026. www.plasticsurgery.org
3. Billa E, Kanakis GA, Goulis DG. Imaging in gynecomastia. *Andrology*. 2021;9(5):1444-1456. doi:10.1111/andr.13051
4. Biro FM, Chan YM. Normal puberty. UpToDate. Updated September 24, 2024. Accessed January 7, 2026. www.uptodate.com
5. Braunstein GD, Anawalt BD. Clinical features, diagnosis, and evaluation of gynecomastia in adults. UpToDate. Updated June 12, 2025. Accessed January 7, 2026. www.uptodate.com

6. Braunstein GD, Anawalt BD. Management of gynecomastia. UpToDate. Updated September 27, 2024. Accessed January 7, 2026. www.uptodate.com
7. Briefing paper: plastic surgery for teenagers. American Society of Plastic Surgeons. Accessed January 7, 2026. www.plasticsurgery.org
8. Hansen J, Chang S. Overview of breast reduction. UpToDate. Updated May 2, 2025. Accessed January 7, 2026. www.uptodate.com
9. Holzmer SW, Lewis PG, Landau MJ, et al. Surgical management of gynecomastia: a comprehensive review of the literature. *Plast Reconstr Surg Glob Open*. 2020;8(10):e3161. doi:10.1097/GOX.0000000000003161
10. Kanakis GA, Nordkap L, Bang AK, et al. EAA clinical practice guidelines-gynecomastia evaluation and management. *Andrology*. 2019;7(6): 778-793. doi:10.1111/andr.12636
11. Kimia R, Magee L, Caplan HS, et al. Trends in insurance coverage for adolescent reduction mammaplasty. Am J Surg. 2022;224(4):1068-1073. doi:10.1016/j.amjsurg.2022.07.030
12. Magny SJ, Shikhman R, Keppke AL. Breast Imaging Reporting and Data System. *StatPearls*. StatPearls Publishing; Updated August 2023. Accessed January 7, 2026. www.ncbi.nlm.nih.gov
13. Mastectomy for gynecomastia. MCG. 29th ed. Updated June 13, 2025. Accessed January 7, 2026. www.careweb.careguidelines.com
14. *Medicaid Provider Manual*. Michigan Dept of Health & Human Services. Accessed January 12, 2026. www.michigan.gov
15. NCCN guidelines for patients 2025: breast cancer screening and diagnosis. NCCN. www.nccn.org
16. Patel K, Corcoran J. Breast reduction surgery in adolescents. *Pediatr Ann*. 2023;52(1):e31-e35. doi:10.3928/19382359-20221114-06
17. Perdikis G, Dillingham C, Boukovalas S, et al. American Society of Plastic Surgeons evidence-based clinical practice guideline revision: reduction mammaplasty. *Plast Reconstr Surg*. 2022;149(3):392e-409e. doi:10.1097/PRS.0000000000008860
18. Reduction mammaplasty. MCG. 29th ed. Updated June 13, 2025. Accessed January 7, 2026. www.careweb.careguidelines.com
19. Reeves RA, Kaufman T. Mammography. *StatPearls*. StatPearls Publishing; 2023. Accessed January 7, 2026. www.ncbi.nlm.nih.gov
20. Schnur PL, Hoehn JG, Ilstrup DM, Cahoy MJ, Chu CP. Reduction mammaplasty: cosmetic or reconstructive procedure? Ann Plast Surg. 1991 Sep;27(3):232-7.
21. Sears ED, Lu YT, Swiatek PR, et al. Use of preoperative mammography during evaluation for nononcologic breast reduction surgery. *JAMA Surg*. 2019;154(4):356-358. doi:10.1001/jamasurg.2018.4875
22. Taylor SA. Gynecomastia in children and adolescents. UpToDate. Updated July 12, 2024. Accessed January 7, 2026. www.uptodate.com
23. Women's Health and Cancer Rights Act (WHCRA). Centers for Medicare and Medicaid Services. Accessed January 7, 2026. www.cms.gov
24. Zeiderman MR, Kelishadi SS, Tutela JP, et al. Reduction mammoplasty: intraoperative weight versus pathology weight and its implications. *Eplasty*. 2017;17:e32. Accessed January 7, 2026. www.pubmed.ncbi.nlm.nih.gov