Protocol

Reduction Mammoplasty

Medical Benefit		**Effective Date**: 01/01/14	**Next Review Date**: 01/15
Preauthorization	Yes	**Review Dates**: 03/07, 03/08, 01/09, 01/10, 01/11, 01/12, 01/13, 01/14	

The following Protocol contains medical necessity criteria that apply for this service. It is applicable to Medicare Advantage products unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. ***Preauthorization is required.*** *Please note that payment for covered services is subject to eligibility and the limitations noted in the patient's contract at the time the services are rendered.*

Description

Reduction mammoplasty is a surgical procedure designed to remove a variable proportion of breast tissue, including the skin and underlying glandular tissue.

Background

Macromastia or gigantomastia is an ill-defined term that describes breast hyperplasia or hypertrophy. Macromastia may result in clinical symptoms such as shoulder, neck, or back pain, or recurrent intertrigo in the mammary folds. In addition, macromastia may be associated with psychosocial or emotional disturbances related to the large breast size. Reduction mammoplasty or mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or relieve the associated clinical symptoms or in conjunction with reconstructive surgery following a complete or partial mastectomy.

For treatment of gynecomastia refer to Cosmetic vs. Reconstructive Surgery or Services.

Related Protocol:

Cosmetic vs. Reconstructive Surgery or Services

Policy (Formerly Corporate Medical Guideline)

Reduction mammoplasty **is medically necessary** for the following:

- To attain symmetry of the non-diseased breast as part of the reconstructive surgery following a mastectomy.

Reduction mammoplasty is **medically necessary** when ALL five of the following non-mastectomy related criteria have been met:

1. Macromastia is causing at least **two** of the following conditions/symptoms with documented failure of at least one continuous three-month trial of appropriate medical management:
    - Back, neck and/or shoulder pain
    - Intertrigo
    - Paresthesias of hands and/or arms
    - Permanent shoulder grooving

AND

2. Macromastia/gigantomastia defined as wearing a bra with a cup size greater or equal to "D"

AND

3. Preoperative photos confirm the presence of BOTH of the following:
   - Significant breast hypertrophy
   - Permanent shoulder grooving from bra straps and/or intertrigo if stated to be present

AND

4. Patient has a body mass index (BMI) of 30 or less to eliminate the possibility that obesity is contributing to these symptoms

AND

5. An estimated tissue reduction of 500 grams per breast or 1000 grams bilaterally is planned. However, removal of less tissue may be considered for an individual of short stature and weight upon review by Medical Director. Information regarding an individual's height and weight must be supplied. In no situations will removal of less than 350 grams per breast be considered medically necessary.

Reduction mammoplasty performed solely to improve one's appearance or self-esteem without signs and symptoms of functional abnormality **is considered cosmetic and not medically necessary**.

Reduction mammoplasty is restricted to age 18 and over as full breast development must occur prior to the surgery.

The use of liposuction to perform breast reduction is considered **investigational**.

Medicare Advantage

Reduction mammoplasty is considered **medically necessary** when the patient has significant symptoms that have interfered with normal daily activities, despite conservative management, for at least six months, including **at least one** of the following criteria:

1. History of back and/or shoulder pain which adversely affects activities of daily living (ADLs) unrelieved by, e.g.:
   - conservative analgesia (e.g., such as NSAID, compresses, massage, etc.)
   - supportive measures (e.g., such as garments, back brace, etc.),
   - physical therapy
   - correction of obesity.
2. History of significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity, e.g.:
   - signs and symptoms of ulnar paresthesias evidenced by nerve conduction studies
   - cervicalgia
   - torticollis
   - acquired kyphosis.
3. Signs and symptoms of:
   - intertrigonous maceration or infection of the inframammary skin (e.g., hyperpigmentation, bleeding,

chronic moisture, and evidence of skin breakdown), refractory to dermatologic measures, or

- shoulder grooving with skin irritation (e.g., areas of excoriation and breakdown) by appropriate supporting garment.

AND

The amount of breast tissue anticipated to be removed is at least 300 grams per breast.

Reduction mammoplasty is also considered **medically necessary** when the patient's normal breast is reduced to achieve symmetry with a breast reconstructed after cancer surgery.

Note: Considerable attention has been given to the amount of breast tissue removed in differentiating between cosmetic and medically necessary reduction mammoplasty.

To be considered a non-cosmetic procedure it is expected that at least a minimal amount of breast tissue will be removed.

There are wide variations in the range of height, weight, and associated breast size that cause symptoms. The amount of tissue that must be removed in order to relieve symptoms will vary and depend upon these variations.

The following are guidelines (not rules) that address the patient's weight and the amount of breast tissue removed:

- 95-119 lbs. 300 grams excised per breast
- 110-130 lbs. 400 grams excised per breast
- 130+ lbs. 500 grams excised per breast

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this Protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

1. "Breast reduction surgery: Decreasing your breast size," Mayo Clinic Staff, 10/5/2005, downloaded www.mayoclinic.com, 2/20/2007.
2. "Reduction Mammaplasty: An Outcome Study," Schnur, et al, Plast Reconstr Surg, 1997.
3. "Breast Reduction Surgery Reveals Significant Positive Physical and Psychological Changes for Women" – Study by ASPRS, Plast Reconstr Surg, 01/99.
4. Abstract. "Should breast reduction surgery be rationed? A comparison of the health status of patient before and after treatment: postal questionnaire survey," Klassen, et al, BMJ, 1996.

5. Abstract. “Long-term results and patient satisfaction with reduction mammaplasty,” Makki & Ghanem, Ann Plast Surg, 1998.
6. New York State Legislation, Cancer Related Benefits, effective 01-01-1998.
7. National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2), 1/1/1997.
8. Local Coverage Determination (LCD): Reduction Mammaplasty (L34186), Original Effective Date for services performed on or after 10/18/2013, Revision Effective Date for services performed on or after 10/25/2013.