

STRIDESM (HMO) MEDICARE ADVANTAGE**Subject: Reduction Mammoplasty**

Background: Individuals with excessively large breasts (macromastia) may seek breast reduction to relieve chronic pain and tension in their neck, shoulders, and upper back.

Considerable attention has been given to the amount of breast tissue removed in differentiating between cosmetic and medically necessary reduction mammoplasty. Although it is expected that at least a minimal amount of breast tissue be removed to be considered a non-cosmetic procedure, 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 to relieve symptoms will vary and depend upon these variations.

Authorization:

Prior authorization from Harvard Pilgrim StrideSM (HMO) is required for all reduction mammoplasty (breast reduction) procedures.

Policy and Coverage Criteria:

Harvard Pilgrim StrideSM (HMO) considers reduction mammoplasty as reasonable and medically necessary when ALL of the following are met:

1. Documentation confirms member's growth is complete; AND
2. Documentation confirms that member has significant symptoms that interfere with normal daily activities, despite conservative management, for at least 6 months; AND
3. The treating surgeon concludes that there is reasonable expectation that symptoms will be relieved by the amount of breast tissue to be removed; AND
4. The member meets ANY of the following criteria:
 - History of back and/or shoulder pain which adversely affects activities of daily living (ADL) unrelieved by ANY of the following:
 - Conservative analgesics (e.g. compresses, massages, nonsteroidal anti-inflammatory drugs [NSAIDs]), OR
 - Supportive measures (e.g. garments, back brace), OR
 - Physical therapy, OR
 - Correction of obesity, OR
 - History of significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity such as:
 - Signs and symptoms of ulnar paresthesias, OR
 - Cervicalgia, OR

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Harvard Pilgrim StrideSM (HMO) policies are based on medical science and relevant information including current Medicare coverage (including National and Local Coverage Determinations), Harvard Pilgrim medical policies, and Harvard Pilgrim StrideSM (HMO) Medicare Advantage Plan materials. These policies are intended to provide benefit coverage information and guidelines specific to the Harvard Pilgrim StrideSM (HMO) Medicare Advantage Plan. Providers are responsible for reviewing the CMS Medicare Coverage Center guidance; in the event that there is a conflict between this document and the CMS Medicare Coverage Center guidance, the CMS Medicare Coverage Center guidance will control.

- Torticollis, OR
- Acquired kyphosis, OR
- Intertriginous 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.

Reduction mammoplasty may be authorized to repair or restore the appearance of one or both breasts when medical record documentation confirms a member has undergone ANY stage of mastectomy, lumpectomy or excisional biopsy, including evaluation/treatment of ANY of the following:

- Breast cyst
- Benign or malignant breast mass
- Aberrant breast tissue
- Duct lesion
- Nipple or areolar lesion

NOTE: Covered services must be provided by contracted vendor(s) with appropriate state licensure, and accreditation/certification from an appropriate accrediting organization. Coverage for reduction mammoplasty unrelated to mastectomy/lumpectomy/excisional biopsy is typically limited to one procedure per member per lifetime. Requests for additional procedures are reviewed and decided on a case-by-case basis.

NOTE: To be considered medically necessary (and not a cosmetic procedure), it is expected that the amount of breast tissue to be removed from each breast can reasonably be expected to improve the patient's symptoms, and in most cases, to meet or exceed the amounts outlined in the Table for Reduction Mammoplasty Criteria (below).

- Minimum breast tissue weight removal criteria may not consistently reflect the consequences of mammary hypertrophy in individuals with a unique body habitus. 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.

Table for Reduction Mammoplasty Criteria*

Member's BSA	Weight (in grams) of Tissue to Be Removed	Member's BSA	Weight (in grams) of Tissue to Be Removed
1.35-1.44	150	2.15-2.19	650
1.45-1.54	200	2.20-2.24	700
1.55-1.64	250	2.25-2.29	800
1.65-1.74	300	2.30-2.34	900
1.75-1.84	350	2.35-2.39	950

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Member's BSA	Weight (in grams) of Tissue to Be Removed	Member's BSA	Weight (in grams) of Tissue to Be Removed
1.85-1.89	400	2.40-2.44	1050
1.90-1.99	450	2.45-2.49	1150
2.00-2.04	500	2.50-2.54	1250
2.05-2.09	550	≥2.55	1350
2.10-2.14	600		

*Listed weights of tissue to be removed are guidelines (not rules) that address the average patient's body surface area (BSA) and the amount of breast tissue removed.

Exclusions:

Harvard Pilgrim StrideSM (HMO) considers reduction mammoplasty as not medically necessary for all other indications. Additionally, Harvard Pilgrim StrideSM (HMO) does not cover:

- Cosmetic surgery to reshape breasts to improve appearance
- Sole use of liposuction for breast reduction surgery

Coding:

Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

CPT® Code	Description
19316	Mastopexy
19318	Reduction mammoplasty

References:

1. Breast Reconstruction for Deformities Unrelated to Cancer Treatment: ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Accessed November 20, 2018.
2. Collins E, Kerrigan C, Kim M et al. The Effectiveness of Surgical and Nonsurgical Interventions in Relieving the Symptoms of Macromastia. *Plastic and Reconstructive Surgery*. 2002;109(5):1556-1566. doi:10.1097/00006534-200204150-00011.
3. Kerrigan C, Collins E, Kim H et al. Reduction Mammoplasty: Defining Medical Necessity. *Medical Decision Making*. 2002;22(3):208-217. doi:10.1177/0272989x0202200309.
4. Kerrigan C, Slezak S. Evidence-Based Medicine. *Plastic and Reconstructive Surgery*. 2013;132(6):1670-1683. doi:10.1097/prs.0b013e3182a807ec.
5. Local Coverage Determination (LCD): Reduction Mammoplasty (L35001). Cmsgov. 2015. Accessed November 20, 2018.
6. Local Coverage Determination (LCD): Cosmetic and Reconstructive Surgery (L34698). Cmsgov. 2015. Accessed November 20, 2018.

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7. Nicoletti G, Scevola S, Faga A. Is breast reduction a functional or a cosmetic operation? Proposal of an objective discriminating criterion. *Journal of Plastic, Reconstructive & Aesthetic Surgery*. 2009;62(12):1644-1646. doi:10.1016/j.bjps.2008.06.069.
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11. Schnur P, Hoehn J, Ilstrup D, Cahoy M, Chu C. Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?. *Annals of Plastic Surgery*. 1991;27(3):232-237. doi:10.1097/00000637-199109000-00007.
12. Schnur P. Reduction Mammoplasty–The Schnur Sliding Scale Revisited. *Annals of Plastic Surgery*. 1999;42(1):107-108. doi:10.1097/00000637-199901000-00020.
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14. Singh K, Losken A. Additional Benefits of Reduction Mammoplasty. *Plastic and Reconstructive Surgery*. 2012;129(3):562-570. doi:10.1097/prs.0b013e31824129ee.
15. Strong B, Hall-Findlay E. How Does Volume of Resection Relate to Symptom Relief for Reduction Mammoplasty Patients?. *Annals of Plastic Surgery*. 2015;75(4):376-382. doi:10.1097/sap.000000000000190.

Summary of Changes:

Date	Changes
1/19	Annual review; no changes

Approved by Clinical Medical Advisory Committee: 1/11/19

Approved by Clinical Policy Operations Committee: N/A

Policy Effective Date: 1/8/19

Initiated: 6/16

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