MEDICAL POLICY STATEMENT
OHIO MEDICAID

Original Issue Date	Next Annual Review	Effective Date
07/20/2003	11/01/2018	11/01/2017-10/31/2018
Policy Name		Policy Number
Breast Reduction Surgery		MM-0020
Policy Type		
MEDICAL	Administrative / Pharmacy	Reimbursement

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) 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 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.

Contents of Policy

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

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 for at least 1 year, as indicated by **2 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. *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*

C. *No evidence of breast cancer*

D. *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.*

E. *Signs and Symptoms described above have not responded to a recent 3 month physician supervised course of conservative therapy, including (but not limited to) a combination of weight loss, appropriate bra support (i.e. properly fitting with wide straps), physical therapy, and/or home exercise program, appropriate medications and appropriate treatment of associated skin conditions.*

II. Physician documentation must include **ALL** of the following:

A. Contemporaneous progress notes outlining the above criteria (1.b. I-VII)

B. Photographic documentation of macromastia (including skin manifestations and shoulder grooving or ulceration from bra straps, if any)

C. The member's bra size, height and weight

D. An estimation of the volume of breast tissue to be removed

III. Mammography: Members 40 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.

IV. Liposuction: The use of liposuction, either entirely or adjunctively for the purpose of breast reduction is considered medically unnecessary.

V. Surgery for Gynecomastia: For medical necessity and criteria for surgery of gynecomastia see CareSource Medical Policy statement for Mastectomy for Gynecomastia.

VI. Breast Asymmetry: For medical necessity and criteria for surgery to correct breast asymmetry see CareSource Medical Policy statement for Breast Reconstructive Surgery.

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). 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).

The body surface area in meters squared (m^2) is calculated using the Mosteller formula as follows:

$$\text{Square root of: } \frac{\text{Ht. (inches)} \times \text{Wt. (lbs.)}}{3{,}131}$$

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

HCPCS
CPT
AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATES	ACTION
Date issued	07/20/2004	
Date Revised	05/25/2005 07/05/2006 09/18/2007 07/01/2009 02/01/2012 12/31/2014 12/01/2015	
	07/26/2017	Annual update, minor editorial revisions, minor changes to policy, removed redundant mastectomy criteria from policy.
Date Effective	11/01/2017	
Date Archived	10/31/2018	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

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. Milliman Care Guidelines (MCG): Ambulatory Care Guidelines (21st Ed., 2017).
6. Kalliainen, L. K. (2012). ASPS Clinical Practice Guideline Summary on Reduction Mammaplasty. *Plastic and Reconstructive Surgery*, *130*(4), 785-789. doi:10.1097/prs.0b013e318262f0c0
7. The Center for Consumer Information & Insurance Oversight; Women's Health and Cancer Rights Act (WHCRA): http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

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.