Medical Affairs Policy

Service: Reduction Mammoplasty for Symptomatic Macromastia
PUM 250-0029

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<tr>
<th>Medical Policy Committee Approval</th>
<th>12/09/16</th>
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<td>Effective Date</td>
<td>01/01/17</td>
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<tr>
<td>Prior Authorization Needed</td>
<td>Yes</td>
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Disclaimer: This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

Description:

This policy does not address mammoplasty related to mastectomy, gender transition, gender dysphoria, or State and Federal Mandated services.

Reduction mammoplasty is the surgical reduction of breast size. This policy addresses surgery for individuals with symptomatic macromastia (abnormally large breasts).

Reduction mammoplasty has been used for the treatment of symptomatic macromastia (symptomatic breast hyperplasia): a syndrome of symptoms including back, neck, and shoulder pain presumed to be the result of large breasts. Findings consistent with symptomatic macromastia are described in Indications of Coverage: Section C.

Reduction mammoplasty is also one of the most commonly performed cosmetic procedures. The criteria in this policy have been established to differentiate between reduction mammoplasty performed for a medically necessary indication versus reduction mammoplasty performed solely for cosmetic purposes, which would generally not be a covered benefit.

Reduction mammoplasty outcomes are primarily described with regard to qualitative benefits. Criteria for identifying individuals who may benefit from reduction mammoplasty have not been definitively established through clinical trials. There is also no consensus regarding the volume of breast tissue removal needed to achieve resolution of symptoms.

The American Society of Plastic Surgeons (ASPS) Clinical Practice Guideline and the ASPS Position Statement recommend, based on the limited evidence and expert opinion, that the criterion for reduction mammoplasty be based on the degree of symptomatology.
rather than by breast volume alone. However, the Schnur scale is widely utilized as an objective tool to determine the minimum amount of tissue to be removed. There is conflicting evidence regarding use of reduction mammoplasty in adolescents.

**Indications of Coverage:**

Reduction mammoplasty is considered medically necessary for the treatment of symptomatic macromastia if **ALL** of the following conditions are met:

A. Documentation of excessively large pendulous natural (no implants) breasts out of proportion to the rest of the individual’s normal or usual body habitus.

B. Pre-operative photographs must confirm the reported clinical findings.

C. The medical record documents a history of **at least three** of the following that have been present for at least one year and are directly attributable to the condition of macromastia:

1. Severe bra strap grooving or ulceration of the shoulder

2. Chronic intertriginous dermatitis despite treatment

3. Pain symptoms (headaches, neck pain, shoulder pain, upper back pain)

4. Breast pain due to the weight of the breasts

5. Ulnar nerve compression, or upper extremity paresthesia (secondary to bra shoulder strap pressure)

6. Restriction of physical activity (e.g. difficulty with exercise) attributed to the macromastia

7. Arm numbness consistent with brachial plexus compression syndrome

D. Documentation from the referring physician or primary care provider that the symptoms are primarily due to macromastia and that other possible causes of the symptoms have been ruled out and treated: **and** the referring physician or primary care provider has documented that reduction mammoplasty is likely to result in improvement of the chronic pain; **and** (if appropriate) orthopedic, neurologic, rheumatologic, and or psychiatric evaluation, and mammography has been performed to address other causes of the complaints identified in Section C.

E. Failure of a three-month trial of conservative therapy that must include both:
1. Pain symptoms treated with physical therapy, chiropractic treatments, and/or exercise, and the concurrent use of anti-inflammatory medications.

2. Improved undergarment support and properly fitted bra.

F. Information from the provider performing the procedure that the amount of tissue that is expected to be removed meets the Schnur Scale criteria based on the patient’s body surface area (BSA). See the table at the end of this guideline for minimum requirements.

BSA is determined using the following formula:

- The square root of:
  - Patient’s height (inches) x Patient’s weight (pounds)

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G. The individual is at least eighteen years of age.

**Limitations of Coverage:**

A. Review contract and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as not medically necessary.

C. If criteria for symptomatic macromastia is not met, deny per plan language.

D. If used for a condition/diagnosis that is listed in the Indications of Coverage but the criteria are not met, deny as not medically necessary.

E. Reduction mammoplasty for the purpose of treating psychological or psychosocial (a psychological condition influenced by the individual’s social environment) symptoms without meeting the objective criteria listed above is considered not medically necessary.

**Documentation Required:**

- Office notes from the consulting or referring physician
- Office notes from the surgeon performing the procedure that must note the amount of breast tissue that is expected to be removed
- Photographs
References:


Review History:

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<tr>
<td>Arise/WPS Policy Committee Approval</td>
<td>12/12/14, 12/11/15, 09/16/16 (Editorial revisions. No changes to criteria), 12/09/16</td>
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- Note: For review/revision history prior to 2014 see previous Medical Policy or Coverage Policy Bulletin CPB 2009-3 Reduction Mammoplasty for Female Macromastia

Approved by the Medical Director