

MEDICA®

UTILIZATION MANAGEMENT POLICY

TITLE: FEMALE BREAST REDUCTION SURGERY – REDUCTION MAMMOPLASTY

EFFECTIVE DATE: August 20, 2018

This policy was developed with input from specialists in plastic surgery and general surgery, and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member's plan document for specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing criteria that generally determine the medical necessity of female breast reduction surgery. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

I. Definitions

- A. **Mammary hyperplasia (macromastia)** is the development of abnormally large breasts. Macromastia is distinguished from large, normal breasts by the presence of persistent, painful symptoms and physical signs.
- B. **Reduction mammoplasty** is surgical excision of mammary tissue and repositioning of the areola and nipple.
- C. **Intertriginous rash** results from dermatitis occurring between juxtaposed folds of skin. The dermatitis is usually caused by retention of sweat, moisture, and warmth which results in an overgrowth of normal skin microorganisms.
- D. **Cellulitis** is an acute spreading bacterial infection (usually *Staphylococcus aureus* or Group A *Streptococcus*) in the deeper layers of the skin (i.e., the dermis and subcutaneous tissues). It is characterized by erythema, warmth, swelling, pain, fever, and malaise. Cellulitis commonly appears in areas where there is a break in the skin from an abrasion, a cut, or skin ulceration. Standard treatment is antibiotic therapy.
- E. **Necrosis** is the death of living cells and tissue. Necrosis is caused by localized tissue injury, such as corrosion or erosion, a lesion or ulceration, or loss of blood supply.
- F. A **skin ulceration** is a break in the skin with accompanying loss of surface tissue with disintegration and necrosis of underlying tissue.
- G. The **Schnur Sliding Scale** is an evaluation tool that is used to determine the appropriate amount of tissue to be removed compared to the individual's total body surface area (BSA).
- H. **Body Surface Area (BSA)** is the area of the external surface of the body, calculated using height and weight and expressed in square meters (m²).

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for breast reduction surgery. Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member's plan document.

3. Cosmetic surgery is generally an exclusion in the member's plan document. However, coverage of all stages of reconstruction of the breast on which a mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance is required by state and federal law.
4. The use of liposuction to perform breast reduction is considered cosmetic and therefore excluded from coverage.
5. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's plan document.
6. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeals process in their Medica Provider Administrative Manual.
7. Refer to Medica's Utilization Management Policy, *Male Gynecomastia Surgery*, for coverage of surgery for male breast enlargement.
8. Refer to Medica's Utilization Management Policy, *Adult Gender Reassignment Surgery*, for coverage of breast reduction and/or mastectomy for gender reassignment.

MEDICAL NECESSITY CRITERIA

I. Indications

Female breast reduction surgery is considered medically necessary when documentation in the medical record indicates that **all of the following** criteria are met. Photographs may be submitted but are not required.

- A. Patient is at least 18 years of age.
- B. Women 40 years of age or older are required to have a mammogram that was negative for cancer within one year prior to the date of the planned procedure.
- C. The amount of tissue to be removed per breast meets **one of the following** criteria:
 1. Is above the 22nd percentile on the Schnur Sliding Scale. See Appendix 1
 2. Expected tissue removal of at least **one of the following**:
 - a. 300 grams per breast for women with height less than 5'2" or weight less than 120 lbs.
 - b. 400 grams per breast for women with height greater than or equal to 5'2" and weight between 120 lbs. and 180 lbs.
 - c. 600 grams per breast for women with height greater than or equal to 5'2" and weight greater than 180 lbs.

NOTE: If significant asymmetry exists, the amount of tissue to be removed from at least one breast must comply with the criteria outlined above.

- D. There is a documented history of macromastia with **at least two of the following** functional impairments, present for six months or greater:
 1. Persistent shoulder grooving
 2. A recurrent or chronic intertriginous rash causing **one of the following**:
 - a. Severe cellulitis, unresponsive to medical treatment
 - b. Skin necrosis or ulceration refractory to medical treatment
 3. Neurologic symptoms related to brachial plexus pressure and/or ulnar paresthesia
 4. Chronic neck, back, and shoulder pain and/or occipital headaches.
- E. Documentation must include **all of the following**:
 1. Amount of breast tissue to be removed
 2. Height and weight or body surface area (BSA) calculation.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: <http://www.cms.hhs.gov/mcd/search.asp>?

DOCUMENT HISTORY

Original Effective Date	October 2005
MPC Endorsement Date(s)	06/2006, 06/2007, 06/2008, 06/2009, 06/2010, 06/2011, 06/2012, 06/2013, 06/2014, 06/2015, 06/2016, 06/2017, 10/2017, 06/2018
Administrative Update(s)	05/2017, 02/2018, 8/2018

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Pre-6/2015 Medical Policy Committee (MPC):

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2. American Society of Plastic Surgeons. *Evidence-based Clinical Practice Guideline: Reduction Mammoplasty*. [http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Reduction_Mammoplasty_Evidence_Based_Guideline%20\(2\)\(2\).pdf](http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Reduction_Mammoplasty_Evidence_Based_Guideline%20(2)(2).pdf). May 2011. Accessed April 15, 2014.
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06/2016 MPC:

No new references.

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No new references.

10/2017 MPC:

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06/2018 MPC:

No new references.

Appendix 1: Schnur Sliding Scale

To calculate body surface area (BSA), see: <http://ebmcalc.com/BodySurfaceArea.htm>
(Du Bois formula)

Body Surface Area (m ²)	Lower 22 nd Percentile Grams of breast tissue
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1,068
2.35	1,167
2.40	1,275
2.45	1,393
2.50	1,522
2.55	1,662