MEDICA UTILIZATION MANAGEMENT POLICY

TITLE: FEMALE BREAST REDUCTION SURGERY – REDUCTION MAMMOPLASTY

EFFECTIVE DATE: October 1, 2016

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 Coverage Issues 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.

II. Comments
   A. Member demand exists for reduction mammoplasty in the absence of functional signs and symptoms, solely to improve the member’s perception of their appearance.
   B. The factors that distinguish appearance-related requests from medically necessary requests are symptoms and physical findings caused by excess breast tissue mass.

**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. Expected tissue removal of at least:
   1. 300 grams per breast for women with height less than 5'2" or weight less than 120 lbs.
   2. 400 grams per breast for women with height greater than or equal to 5'2" and weight between 120 lbs. and 180 lbs.
   3. 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 grams 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.

**COVERAGE ISSUES**
1. Prior authorization is **required** for breast reduction surgery.
2. Coverage may vary according to the terms of the member’s plan document.
3. For Medicare members, refer to the following criteria, as applicable:
4. 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.
5. The use of liposuction to perform breast reduction is considered cosmetic and therefore excluded from coverage.
6. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s plan document.
7. 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.
8. Refer to Medica’s Utilization Management Policy, **Male Gynecomastia Surgery**, for coverage of surgery for male breast enlargement.
9. Refer to Medica’s Utilization Management Policy, **Adult Gender Reassignment Surgery**, for coverage of breast reduction and/or mastectomy for gender reassignment.

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Original Effective Date</th>
<th>October 2005</th>
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<tbody>
<tr>
<td>Administrative Update(s)</td>
<td>05/01/2017</td>
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References

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


06/2015 MPC:


06/2016 MPC:

No new references.

Effective Date: October 1, 2016