



Medicare Part C Medical Coverage Policy

Breast Reduction

Origination: September 8, 1988
Review Date: April 17, 2019
Next Review: April, 2021

******This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE OR SERVICE

Reduction mammoplasty is the surgical reshaping of the breasts to reduce or lift enlarged or sagging breasts. It results in a significant reduction in the size of the breast, change in shape and an uplifting effect on the breast tissue. The procedure may be covered when medically indicated to relieve symptoms resulting from breast macromastia.

Macromastia (breast hypertrophy) is an increase in the volume and weight of breast tissue relative to the general body type or structure. Breast hypertrophy may adversely affect other body systems, such as musculoskeletal, respiratory, and integumentary.

POLICY STATEMENT

Coverage will be provided for breast reduction when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations;
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (E.O.C.), the E.O.C. always governs the determination of benefits.

INDICATIONS FOR COVERAGE

Preauthorization by the Plan is required;

AND

Reduction Mammoplasty is covered when A, B and C are met; OR D:

A. There is documentation of at least one of the following:

1. Symptomatic back pain, neck pain and shoulder pain from macromastia that is unrelieved by 6 months of medical treatment such as:
 - a. conservative analgesia; **OR**
 - b. supportive measures (garments, etc.); **OR**
 - c. Physical therapy. **OR**
2. Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity; **OR**
3. Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures; **OR**
4. Permanent shoulder grooves with skin irritation related to breast weight and supporting garment (bra strap).

AND

B. There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions such as, but not limited to the following:

1. Determining the macromastia is not due to an active metabolic or endocrine or metabolic process;
2. Determining the symptoms are refractory to appropriately fitted supporting garments, or following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast;
3. Determining that dermatologic signs and/or symptoms are refractory too, or recurrent following a completed course of medical management;

AND

C. The anticipated amount of breast tissue to be removed for each breast is proportional to the body surface area (BSA) per the Schnur scale below:

BSA:	Grams of tissue to be removed per breast:
1.40-1.50	218-260
1.51-1.60	261-310

1.61-1.70	311-370
1.71-1.80	371-441
1.81-1.90	442-527
1.91-2.00	528-628
2.01-2.10	629-750
2.11-2.20	751-895
2.21-2.30	896-1068
2.31-2.40	1069-1275
2.41-2.50	1276-1522
2.51-2.60	1523-1806
2.61-2.70	1807-2154
2.71-2.80	2155-2568
2.81-2.90	2569-3061
2.91-3.00:	3062-3650

OR

- D. To improve symmetry following mastectomy, related to cancer or other medical condition, on one breast.

WHEN COVERAGE WILL NOT BE APPROVED

1. Reduction mammoplasty is not covered when the criteria listed above have not been met.
2. Cosmetic surgery to reshape the breasts to improve appearance is not covered.

COVERED CODES/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes: 19318

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

SPECIAL NOTES

See EOC for guidelines regarding coverage of reconstructive breast surgery.

NOTE: If one breast is macromastic and the weight of the removed breast tissue meets or exceeds the guidelines for coverage, the opposite breast not meeting guidelines would be considered for reduction mammoplasty, if reduction is necessary to obtain symmetry.

GLOSSARY OF TERMS

Schnur Scale: an evaluation method for physicians to use on individuals considering breast reduction surgery. This method was developed by a plastic surgeon for use in a study that was done to determine the number of women who had breast reduction surgery for medical reasons only. Body surface area, along with average weight of breast

tissue removed is incorporated into the chart to indicate the reason/motivation of the individual for breast reduction surgery. If the individual's body surface area and weight of breast tissue removed fall below the lower 22nd percentile, then the surgery is deemed not medically necessary. If the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically necessary with the appropriate criteria.

References:

1. Medicare Local Coverage Determination for Cosmetic and Reconstructive Surgery – Palmetto gba Part A/B (L33428); Effective Date 10/01/2015. Accessed via www.cms.gov 4/3/2019.
2. Medicare Local Coverage Determination for Cosmetic and Reconstructive Surgery – Wisconsin Physicians Service Part A (L34698); Effective Date 10/01/2015. Accessed via www.cms.gov 4/3/2019.

Policy Implementation/Update Information:

Revision Dates: March 14, 1995; December 15, 1997; January 25, 1999; September 29,1999; October 25,1999; May 22, 2000; September 19, 2001; October 1, 2001; October 11, 2001; October 15, 2001; December 8, 2004; June 28, 2006.

Revision Date: September 2009: No changes proposed to the review criteria. Formatting and minor wording changes only. Added reference to Schnur scale.

Revision Date: 1/5/11: LCD L28222 and L17995 both retired as of 11/15/10. New CMS policy LCD L30733 added as reference. Description of Procedure or Service section updated per new CMS policy. Indications for Coverage section Section I: minor language edits per new CMS policy; Section IV: additional Schnur scale indicators added per new CMS policy.

Revision Date: May 15 2013; reformatted policy.

Revision Date: May 20, 2015: Annual review, no CMS criteria updates, updated reference section. October 29, 2015 updated LCD due to ICD-10 update only.

Revision Date: May 17, 2017: Annual Review. No CMS criteria updates, Minor revisions only.

Revision Date: April 17, 2019. Annual Review. No CMS Updates. Minor revisions only.

Revision Date: September 18, 2019; Staff Clarification. Removed Medical Director Review Requirement.

Approval Dates:

Medical Coverage Policy Committee: September 18, 2019

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