Breast Reduction Mammoplasty

**Medical Guideline Disclaimer**

Property of EmblemHealth. All rights reserved. The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, (“EmblemHealth”) has adopted the herein policy in providing management, administrative and other services to Health Insurance Plan of Greater New York and Group Health Incorporated, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

**Definitions**

| Cosmetic surgery | Performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem. |
| Mastopexy         | Plastic surgery to move sagging breasts into a more elevated position. It involves the repositioning of the nipple and areola and is sometimes performed in conjunction with implant insertion. |
| Reconstructive surgery | Performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance (e.g., following a mastectomy for breast cancer). |

**Related Medical Guidelines**

- Cosmetic Surgery Procedures
- Gender Reassignment Surgery

**Guideline**

Members are eligible for breast reduction mammoplasty.

For Plan consideration, breast photographs must be submitted for review; these must include unobstructed frontal and lateral views, shoulder to waist.

For women ≥ 40, or younger if there is a positive family history (first degree relatives only) of breast cancer, documentation must also include a mammogram negative for cancer within the last 2 years of the scheduled surgery date.

Reduction mammoplasty is approved for the achievement of symmetry of the non-cancerous breast to the reconstructed breast after breast cancer surgery; regardless of the size of the unaffected breast.
**All** of the following criteria must be met:

1. **Age ≥ 18 and completed pubertal and skeletal development**

2. **Presence of clinically significant and persistent symptoms that have caused functional impairment for ≥ 1 year**
   
   Symptoms and objective findings must be documented by the physician in the progress notes as directly related to macromastia and include **any** of the following:
   
   - Presence of severe intertriginous dermatitis (photos must display intertrigo) unresponsive to medical management
   - Presence of thoracic or cervical pain syndrome (e.g., upper back, neck, or shoulder pain [excluding lower back pain]), that is not related to causes other than excessive breast weight. The syndrome should be unresponsive to conservative treatment, including both analgesia and nonsteroidal anti-inflammatory medications
   - Presence of ulnar nerve compression with documented paresthesia secondary to coracoid process descent
   - Presence of dorsal kyphosis or compensatory lordosis documented by X-rays

3. **The amount of breast tissue to be removed must be proportional to the body surface area (BSA)** per the Schnur scale in the table below with the estimate provided at time of pre-service review.

<table>
<thead>
<tr>
<th>BSA</th>
<th>Grams of tissue to be removed per breast</th>
<th>BSA</th>
<th>Grams of tissue to be removed per breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.40–1.50</td>
<td>218–260</td>
<td>1.91–2.00</td>
<td>528–628</td>
</tr>
<tr>
<td>1.51–1.60</td>
<td>261–310</td>
<td>2.01–2.10</td>
<td>629–750</td>
</tr>
<tr>
<td>1.61–1.70</td>
<td>311–370</td>
<td>2.11–2.20</td>
<td>751–895</td>
</tr>
<tr>
<td>1.71–1.80</td>
<td>371–441</td>
<td>2.21–2.30</td>
<td>896–1068</td>
</tr>
<tr>
<td>1.81–1.90</td>
<td>442–527</td>
<td>2.31–2.40</td>
<td>1069–1275</td>
</tr>
</tbody>
</table>

* BSA (m²) = ((height (cm) x weight (kg))/ 3600)⁰⁵⁷; BSA calculator may be found at [http://www.calculatorpro.com/body-surface-area-calculator](http://www.calculatorpro.com/body-surface-area-calculator)

**Limitations/Exclusions**

1. Breast reduction mammoplasty is not medically appropriate for any of the following:
   
   - Claims of inability to exercise
   - Fibrocystic disease
   - Improperly fitting clothing
   - Psychological or social reasons
   - Any other solely cosmetic reason to improve appearance (e.g., breast asymmetry for a member who does not meet the above criteria)

2. Mastopexy is covered when associated with a reconstructive procedure
Applicable Procedure Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19318</td>
<td>Reduction mammaplasty</td>
</tr>
</tbody>
</table>

Applicable ICD-10 Diagnosis Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N62</td>
<td>Hypertrophy of breast</td>
</tr>
</tbody>
</table>

References


Specialty-matched clinical peer review.