Reduction Mammoplasty

Origination: 11/26/96	**Revised:** 12/18/23	**Annual Review:** 12/19/23
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☒ Commercial, QHP/Exchange, & Medicare ☐		

Purpose:

To provide reduction mammoplasty guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Additional Information

- As noted in the Clinical Practice Guidelines for Plastic and Maxillofacial Surgery published by the American Society of Plastic and Reconstructive Surgeons, Inc., section on reduction mammoplasty, the diagnosis of female breast hypertrophy is used to describe an increase in the volume and weight of breast tissue in excess of the normal proportion. While the response is usually symmetric involvement of both breasts, occasional cases of unilateral hypertrophy occur. Breast hypertrophy may also become symptomatic after mastectomy on the opposite breast.[1]

- The diagnosis of female breast hypertrophy involves a comparison of overall body stature with breast size as determined by nipple position and an estimate of excess breast tissue weight. There is a wide variation in female breast size and a transition from normal breast size to symptomatic breast hypertrophy.[1]

- Coverage guidelines for male gender are addressed in a separate procedure.

Coverage Guidelines

These Coverage Guidelines apply to Commercial HMO Members (female gender) as determined by individual contractual benefits

CPT Code: 19318 Reduction Mammaplasty (Mammoplasty)

1.0 Reduction mammaplasty (mammoplasty) is indicated for *macromastia when **ALL*** of the following are present:

1.1 Large breast size in relation to body, requiring removal of an average weight of tissue that is planned to be removed in each breast above the 22nd percentile on the Schnur Sliding Scale (see Appendix) based on the individual's body surface area (BSA);

1.2 Signs and symptoms that cause significant interference with daily life which are directly attributable to large breast size, for at least one (1) year, which may include[3]:

- 1.2.1 Headaches;
- 1.2.2 Shoulder pain;
- 1.2.3 Upper or lower back pain;
- 1.2.4 Persistent intertrigo (i.e. redness and erythema) with or without ulceration, below breasts;
- 1.2.5 Nipple position greater than 21 cm below suprasternal notch;
- 1.2.6 Restriction of physical activity;

1.3 Documented history of failed course of conservative treatment for relevant presenting symptoms, which includes[3]:

- 1.3.1 Physical therapy (minimum of four [4] to eight [8] visits with physical therapy or chiropractic care and a minimum of three [3] months of home exercise within the last six [6] months);
- 1.3.2 Trial of nonsteroidal anti-inflammatory medications (NSAIDS) for at least three (3) months within the last six (6) months;
- 1.3.3 Intertrigo treated with topical and oral antifungal agents for at least three(3) months within the last six (6) months;

1.4 Must be 18 years of age or older;

1.5 Pre-operative photograph must be submitted and confirm severe breast hypertrophy.

Documentation Requirements:[2]

2.0 The medical file must be available for review (e.g., pre-authorization and/or retrospective review) upon request and must provide the following information: [2]

2.1 Clinical evaluation of the signs and/or symptoms ascribed to the macromastia (gynecomastia), and

2.2 Documentation that supports the Coverage Guidelines section of this Procedure;

2.3 Pre-operative photograph(s);

2.4 Pathology report(s).[2]

Appendix

Body Surface Area and Cutoff Weight of Breast Tissue Removed
Breast Reduction (gm)

BSA = ($W^{0.425}$ x $H^{0.725}$) x 0.007184 (Weight is in kilograms and the Height is in centimeters)

Body Surface Area (m2)	Lower 5%	Lower 22%
1.35	127	199
1.40	139	218
1.45	152	238
1.50	166	260
1.55	181	284
1.60	198	310
1.65	216	338
1.70	236	370
1.75	258	404
1.80	282	441
1.85	308	482
1.90	336	527
1.95	367	575
2.00	401	628
2.05	439	687
2.10	479	750
2.15	523	819
2.20	572	895
2.25	625	978
2.30	682	1068
2.35	745	1167
2.40	814	1275
2.45	890	1393
2.50	972	1522
2.55	1062	1662

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References:

1. American Society Of Plastic and Reconstructive Surgeons, Inc. *Clinical Practice Guidelines, Female Breast Hypertrophy/Breast Reduction.* September, 1993.

2. *Florida Medicare Part B* Local Medical Review Policy.

3. *Milliman Care Guidelines® Ambulatory Care 12th Edition Reduction Mammaplasty (Mammoplasty) (Women's Health) ACG: A-0274(AC).*

4. *American Society of Plastic Surgeons (ASPS), Reduction Mammaplasty*. ASPS Recommended Coverage Criteria for Third Party Payers. Arlington Heights, IL, ASPS: March 9, 2002.

5. Schnur Sliding Scale (Schnur, et al., Ann Plast Surg. 1991 Sep;27(3):232-7**).**

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.