

Medical Policy

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## Breast Reduction Surgery

**Policy Number:** OCA 3.44

**Version Number:** 22

**Version Effective Date:** 08/01/21

### Product Applicability

**All Plan<sup>+</sup> Products**

#### Well Sense Health Plan

Well Sense Health Plan

#### Boston Medical Center HealthNet Plan

MassHealth ACO

MassHealth MCO

Qualified Health Plans/ConnectorCare/Employer Choice Direct

Senior Care Options ◊

**Notes:**

+ Disclaimer and audit information is located at the end of this document.

◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at [www.SeniorsGetMore.org](http://www.SeniorsGetMore.org) to determine coverage guidelines for Senior Care Options.

### Policy Summary

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Breast reduction surgery (reduction mammoplasty) is considered **medically necessary** for symptomatic macromastia when Plan criteria are met for a female member (or a member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes). The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member’s condition. Plan prior authorization is required for reduction mammoplasty. If applicable medical criteria are NOT met, the surgery is considered cosmetic.

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In accordance with Massachusetts state-mandated benefits, the Plan covers medically necessary treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome for a BMC HealthNet Plan member (i.e., Massachusetts resident enrolled in the Plan's MassHealth, Qualified Health Plans, or Senior Care Options product). Review the *Gynecomastia Surgery* medical policy (policy number OCA 3.48) for medical necessity criteria for gynecomastia surgery (including but not limited to the surgical treatment for gynecomastia to reduce HIV-associated lipohypertrophy of the chest). See the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69, rather than this policy for medical necessity criteria for the following indications for treatment: Treatment of HIV-associated lipodystrophy when it is not associated with gynecomastia surgery (e.g., liposuction/suction assisted lipectomy, autologous fat grafts, reconstructive breast procedures, and/or dermal filler injections for the treatment of facial lipoatrophy syndrome) and/or the treatment of lipodystrophy when the condition is not associated with HIV. For pharmacotherapy, see the Plan's applicable pharmacy policies available at [www.bmchp.org](http://www.bmchp.org) for BMC HealthNet Plan members and posted at [www.wellsense.org](http://www.wellsense.org) for Well Sense Health Plan members; pharmacy policies include prior authorization guidelines and medical necessity criteria for the Plan's covered drug list (categorized by medical drug name), including but not limited to the Plan's *Egrifta*® pharmacy policy, policy number 9.032.

Review the Plan's *Gynecomastia Surgery* medical policy, policy number OCA 3.48, for applicable medical criteria for the surgical removal of glandular breast tissue for a male member (or a member born with male reproductive organs and/or typical male karyotype with only one [1] X chromosome), including but not limited to the surgical treatment for gynecomastia to reduce HIV-associated lipohypertrophy of the chest. The Plan's *Breast Reconstruction* medical policy, policy number OCA 3.43, specifies the prior authorization guidelines for the surgical removal of breast implants and/or the replacement of breast implants after implant explantation (including when the implant was initially inserted as a component of a gender affirmation surgery). Review the Plan's *Gender Affirmation Surgeries* medical policy, policy number OCA 3.11, to determine the medical necessity of chest reconstructive procedures used to treat gender dysphoria (e.g., treatment of gender dysphoria with breast augmentation, mastectomy, breast reconstruction with flaps, mastopexy, and/or breast reduction surgery).

It will be determined during the Plan's prior authorization process if the procedure is considered medically necessary for the requested indication. The Plan's *Medically Necessary* medical policy, policy number OCA 3.14, indicates the product-specific definitions of medically necessary treatment. The Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69, includes the medical necessity criteria for the following indications for treatment: Treatment of HIV-associated lipodystrophy when it is not associated with gynecomastia surgery (e.g., liposuction/suction assisted lipectomy, autologous fat grafts, reconstructive breast procedures, and/or dermal filler injections for the treatment of facial lipoatrophy syndrome) and/or the treatment of lipodystrophy when the condition is not associated with HIV.

#### Breast Reduction Surgery

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## Description of Item or Service

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**Breast Reduction Surgery (Reduction Mammoplasty/Mammoplasty):** Surgical excision of a substantial portion of breast tissue, including the skin and underlying glandular tissue, to achieve a proportionate reduction in breast size using standard calculations based on body surface area (BSA).

## Medical Policy Statement

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The Plan considers breast reduction surgery (reduction mammoplasty) to be medically necessary for symptomatic macromastia or when the procedure is related to breast reconstruction after lumpectomy or mastectomy for a female member (or a member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes). The treating provider should discuss with the member **breast feeding considerations** related to breast reduction mammoplasty as a component of the evaluation for surgery. The treating provider must verify that the member is an acceptable surgical candidate (with evaluation of the member's high-risk indicators, if any, such as morbid obesity, tobacco use, cardiac history, comorbidities, and related past medical/surgery history). The Plan's applicable medical necessity criteria must be met for reduction mammoplasty and documented in the member's medical record (including preoperative photographs, which will be submitted as part of the prior authorization review process if requested by the Plan), as specified below in EITHER item 1 (Reduction Mammoplasty for Macromastia) or item 2 (Reduction Mammoplasty as Part of Breast Reconstruction after Mastectomy or Lumpectomy):

1. **Breast Reduction Surgery (Reduction Mammoplasty) for Breast Hypertrophy, Gigantomastia, or Macromastia:**

ALL of the following criteria must be met, as specified below in items a through f:

a. Age Criteria:

ONE (1) of the following applicable criteria is met, as specified below in item (1) or item (2):

- (1) Pediatric member is 15-17 years of age on the date of service and the following criteria are met for the female pediatric member (or a pediatric member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes<sup>†</sup>), as specified below in items (a) through (c):
  - (a) Documented Tanner stage IV or stage V (full physical maturity); AND
  - (b) Breast/cup size has been stable for at least 6 consecutive calendar months prior to surgery; AND
  - (c) At least ONE (1) of the following growth parameters is met, as specified below in item i or item ii:

Breast Reduction Surgery

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- i. Stable height measurements for at least 6 consecutive calendar months prior to surgery; AND/OR
  - ii. Wrist radiograph has confirmed the completion of puberty prior to surgery; OR
- (2) Adult female member (or an adult member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes<sup>‡</sup>) is age 18 or older on the date of service; AND
  - ‡ Note: The Plan will review requests for breast reconstruction procedures for gender reassignment using the medical criteria included in the *Gender Affirmation Surgeries* medical policy, policy number OCA 3.11, rather than other Plan medical policies related to the requested breast procedure.
- b. Member has a diagnosis of symptomatic breast hypertrophy, gigantomastia, or macromastia and the estimated minimum weight of excess breast tissue per breast and the amount of total body surface area (BSA) in square meters (m<sup>2</sup>) to be removed meets ONE (1) of the following criteria, as specified below in items (1) through (4):
  - (1) 199 grams to 238 grams of tissue per breast to be removed with BSA 1.35 to 1.45 m<sup>2</sup>; OR
  - (2) 239 grams to 284 grams of tissue per breast to be removed with BSA 1.46 to 1.55 m<sup>2</sup>; OR
  - (3) 285 grams to 349 grams of tissue per breast to be removed with BSA 1.56 to 1.69 m<sup>2</sup>; OR
  - (4) 350 grams or greater of tissue per breast to be removed; AND
- c. The treating provider has determined that the member has a reasonable prognosis of symptomatic relief after reduction mammoplasty; AND
- d. Documentation includes at least TWO (2) of the following clinical findings, as specified below in items (1) through (8):
  - (1) Symptoms of persistent pain in the upper back, neck, and/or shoulders that have interfered with activities of daily living for at least 6 calendar months within the past 12 consecutive months prior to this prior authorization request, and pain is unresponsive to conservative treatments for at least 3 calendar months that include

Breast Reduction Surgery

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but are not limited to physical therapy and pharmacotherapies (e.g., anti-inflammatories and analgesics);

- (2) Intractable cervicodorsal myositis (i.e., inflammation of the back and neck muscles) for at least six (6) calendar months and the condition is unresponsive to medical therapy;
  - (3) Tissue ulcerations, dermatitis (e.g., intertrigo), and/or eczema of the inframammary fold are unresponsive to dermatological treatment;
  - (4) Upper extremity paresthesia due to brachial plexus compression syndrome;
  - (5) Painful and permanent shoulder grooving (defined as deep grooves in the shoulder with pain and discomfort from bra straps) despite the use of a support bra with weight distributing straps;
  - (6) Gigantomastia in pregnancy when delivery is not imminent;
  - (7) Chronic breast pain (defined as breast pain lasting six [6] calendar months or longer) due to breast weight that is unresponsive to conservative treatments such as support garments;
  - (8) Painful thoracic kyphosis documented by radiographs; AND
- e. Comorbid etiologies of the member's symptoms (as specified above) have been ruled out (i.e., combination of medical conditions/risk factors that may increase the occurrence of macromastia and associated symptoms); AND
- f. Member 40 years of age or older has had a mammogram within 12 calendar months from the date of the planned reduction mammoplasty that was negative for cancer in both breasts;≈ OR

≈ Note: All female members (or members born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes) under the age of 40 who are symptomatic or have an associated high-risk factor for breast cancer should be screened prior to breast reduction surgery.

## 2. **Reduction Mammoplasty as Part of Breast Reconstruction after Mastectomy or Lumpectomy:**

BOTH of the following criteria must be met for a member after a diagnosis of breast cancer, as specified below in item a and item b:

- a. Reduction mammoplasty will be performed to reduce the size of an unaffected breast to bring it into symmetry with a breast reconstructed after mastectomy or lumpectomy (either

Breast Reduction Surgery

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oncoplastic reduction mammoplasty or reduction mammoplasty following mastectomy or lumpectomy); AND

- b. Member has had a mammogram within 12 calendar months from the date of the planned reduction mammoplasty that was negative for cancer, including the unaffected side if used to create symmetry after breast surgery related to breast cancer (unless oncoplastic reduction mammoplasty is performed concurrently with the breast surgery related to breast cancer treatment and then the criterion requiring a mammogram negative for cancer would not be applicable).

## Limitations

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ANY of the following limitations applies to breast reduction surgery (reduction mammoplasty), as specified below in items 1 through 4:

1. The Plan considers suction assisted lipectomy or liposuction as a sole method of surgical treatment for reduction mammoplasty to be cosmetic and NOT medically necessary.
2. Breast reduction surgery is considered cosmetic (and NOT medically necessary) for poor posture, breast asymmetry, pendulousness, problems with clothes fitting properly, nipple-areola distortion, and/or psychological considerations when the Plan's applicable clinical review criteria specified in the Medical Policy Statement section of this policy are NOT met. Any request for breast reduction surgery that does NOT meet the Plan's medical necessity criteria requires individual consideration by a Plan Medical Director. The Plan Medical Director will evaluate the individual member's clinical needs and circumstances based on the guidelines described in the Plan's *Clinical Review Criteria* administrative policy, policy number OCA 3.201.
3. A request for breast reduction surgery for a member age 13 or age 14 on the date of service requires Medical Director review with documentation that the member's breast/cup size has been stable for at least 6 consecutive calendar months, as well as documentation that all other applicable medical necessity criteria are met in the Medical Policy Statement section.
4. Repeat reduction mammoplasty is NOT considered medically necessary unless there are complications resulting from the initial procedure. Plan Medical Director review is required for individual consideration.

## Definitions

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**Gigantomastia:** A rare condition of massive diffuse enlargement of breast tissue in one or both breasts associated with pregnancy (gestational gigantomastia), puberty, a side effect of certain medications (drug-induced gigantomastia), and/or a symptom of some autoimmune conditions. The resulting hypertrophy is not only grotesquely deforming, but also may preclude ambulation or progress to skin ulceration, infection, or massive bleeding from dilated subcutaneous veins; these complications may

Breast Reduction Surgery

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be life threatening. The etiology is unknown. Idiopathic gigantomastia, the most common type of gigantomastia, occurs spontaneously with no obvious cause.

**HIV-Associated Lipodystrophy:** Abnormal fat accumulation (lipohypertrophy), localized loss of fat tissue (lipoatrophy), or a combination of both that are associated with metabolic complications (such as dyslipidemia, glucose intolerance, and insulin resistance) and contribute to HIV-related morbidity and mortality through increased cardiovascular and cerebrovascular disease risk. The syndrome occurs in HIV-infected patients treated with antiretroviral medications (e.g., protease inhibitors and nucleoside reverse transcriptase inhibitors). HIV may be a causal factor for lipodystrophy by interfering with way the body processes adipose tissue. Treatment for HIV-associated lipodystrophy may include conservative treatment (diet modification and exercise), pharmacotherapy, or surgical intervention when conservative treatment and drug therapy are not effective. The magnitude of fat loss determines the severity of metabolic complications and associated treatment plan.

**Intertrigo (also known as Intertriginous Dermatitis):** An inflammatory, superficial skin disorder involving any area of the body where opposing skin surfaces may touch and rub, such as the creases of the neck, between the toes, or in the skin folds of the groin, axilla, and breasts (especially if large and pendulous). The condition is characterized by skin reddening, maceration, burning, and itching. There may also be secondary infections, as well as erosions, fissures, and exudation.

**Lipodystrophy:** A medical condition resulting in abnormal fat accumulation (lipohypertrophy), localized loss of fat tissue (lipoatrophy), or a combination of both with metabolic complications (such as dyslipidemia, glucose intolerance, and insulin resistance). With lipoatrophy, there is selective, subcutaneous fat loss (either partial or near total absence of adipose tissue) from various regions of the body, generally occurring in the limbs, face, and/or buttocks. Lipohypertrophy (fat accumulation), when present, most commonly occurs in the abdomen, dorsocervical area (developing fat pad enlargement known as buffalo hump), and the breast/chest. In addition, lipomas may develop in other parts of the body. A disruption in the total amount and distribution of adipose tissue (as an active endocrine organ) contribute to metabolic abnormalities that alter hormone levels secreted by adipose tissue. The magnitude of fat loss determines the severity of metabolic complications and may result in dyslipidemia and abnormal glucose metabolism (predisposing the patient to cardiovascular disease and diabetes mellitus). The physical changes associated with the lipodystrophy syndrome can be divided into three (3) major types: lipoatrophy or fat wasting; lipohypertrophy or fat accumulation; and mixed forms with atrophy and hypertrophy coexisting in different body regions. Men tend to experience lipoatrophy and women are more likely to have lipohypertrophy. Withdrawal of antiretroviral therapy and therapeutic strategies do not achieve substantial improvements and may not be medically appropriate. Two major types of lipodystrophies are inherited (familial or genetic lipodystrophies) or secondary to a medical condition or drug treatment (e.g., HIV-associated lipodystrophy).

**Macromastia (also known as Breast Hypertrophy):** The development of abnormally large breasts in a female (or an individual born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes). Symptomatic macromastia is a condition where large breasts cause chronic pain and heaviness of the breasts and other physical problems such as: pain or constant

Breast Reduction Surgery

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tension in the neck, shoulders, chest wall and/or back; headaches; poor posture; numbness and tingling of the hands; shortness of breath; sleep disturbances; rashes under and between the breasts and in the bra strap grooves; shoulder grooving; and/or brachial plexus syndrome. Symptoms are often present for several years and usually worsen at the end of the day after maintaining upright posture for an extended period of time. The etiology of macromastia is usually undetermined, but the condition may be caused by glandular hypertrophy, excessive fatty tissue, or a combination of both and is often related to the individual's body type and hereditary characteristics. Individuals may seek breast reduction surgery to treat symptomatic macromastia that cannot be medically managed with treatments such as anti-inflammatory medications, heat packs, and/or physical therapy.

**Oncoplastic Breast Reconstruction:** The surgical management of breast cancer with complete resection of the tumor, preservation of normal tissue, immediate breast reconstruction of the affected breast at the time of the surgical treatment for breast cancer, and may also include symmetrizing surgery for the contralateral breast to improve aesthetic outcomes and patient satisfaction.

**Schnur Sliding Scale:** Method used to determine if the proposed amount of tissue resection to reduce breast size is appropriate in comparison to body size. Using this method, the body surface area (BSA) is compared to the proposed weight of breast tissue to be removed.

The DuBois and DuBois formula is used to calculate the BSA:

$$\text{BSA (m}^2\text{)} = 0.20247 \times \text{Height (m)}^{0.725} \times \text{Weight (kg)}^{0.425}$$

Further details regarding this formula can be accessed at: <http://www.medcalc.com/body.html>

## Applicable Coding

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The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under

Breast Reduction Surgery

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the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

<b>CPT Code</b>	<b>Description: Code Covered When Medically Necessary</b>
19318	Breast reduction

## **Clinical Background Information**

Macromastia can cause significant clinical manifestations when excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk. This condition can sometimes lead to debilitating conditions that include chronic shoulder pain, chronic neck pain, chronic back pain, skin rash and infection to the area under the breast, painful shoulder grooving from bra straps, and/or decreased activity levels. These conditions may be improved by reduction mammoplasty surgery, with associated clinical signs and symptoms alleviated in appropriately chosen cases.

Members considering reduction mammoplasty who have been determined to be appropriate candidates for a bariatric procedure are encouraged to pursue the bariatric surgery before proceeding with the reduction mammoplasty. Massive weight loss before the reduction mammoplasty has been associated with increased patient satisfaction with reduction mammoplasty results, while massive weight loss following reduction mammoplasty has been associated with decreased patient satisfaction with the reduction mammoplasty results.

Early detection with imaging studies can prevent the development of life-threatening breast cancer. Mammography, ultrasonography, and/or magnetic resonance imaging (MRI) may be recommended before performing a breast procedure to detect breast cancer. There is no industry-wide consensus on breast cancer screening criteria, but guidelines are endorsed by the American Cancer Society (ACS), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), American College of Radiology (ACR), American Medical Association (AMA), National Cancer Institute (NCI), National Comprehensive Cancer Network (NCCN), and the United States Preventive Services Task Force (USPSTF)

At the time of the Plan’s most recent policy review, the following applicable clinical guidelines were found from the Centers for Medicare & Medicaid Services (CMS) for breast surgery: National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2), NCD for Mammograms (220.4), Local Coverage Determination (LCD) for Cosmetic and Reconstructive Surgery (L34698), and LCD for Reduction Mammoplasty (L35001). No CMS clinical guidelines were identified specifically for mastopexy surgery during the policy review process. CMS guidelines for the medically necessary treatment of lipodystrophy only include dermal injections for the treatment of facial lipodystrophy syndrome (LDS) using FDA-approved dermal fillers with HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to the patient’s depression. Verify if applicable CMS criteria are in effect for the requested breast procedure in an NCD or LCD on the date of the prior authorization request for a Senior Care Options member.

Breast Reduction Surgery

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#### Breast Reduction Surgery

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## Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/06/05	06/09/06 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

\*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12

Breast Reduction Surgery

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\*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13

\*Effective Date for the Senior Care Options Product(s): 01/01/16

Policy title was *Breast Reduction Mammoplasty in Females* from 06/09/16 to 10/31/16. The policy title was *Breast Reduction Mammoplasty* from 11/01/16 to 12/31/20. As of 01/01/21, the policy title has been changed to *Breast Reduction Surgery*.

<b>Policy Revisions History</b>			
<b>Review Date</b>	<b>Summary of Revisions</b>	<b>Revision Effective Date and Version Number</b>	<b>Approved by</b>
05/09/06	Removed the requirement for a pre-operative mammogram to be submitted prior to authorization.	Version 2	05/09/06: Q&CMC
05/08/07	Updated clinical criteria, template, added coding, and references.	Version 3	06/14/07: MPCTAC 06/26/07: Utilization Management Committee (UMC) 07/12/07: Quality Improvement Committee (QIC)
05/13/08	Added information on how to calculate the BSA based upon the DuBois Formula.	Version 4	05/13/08: MPCTAC 05/20/08: UMC 05/28/08: QIC
05/26/09	Clarified clinical criteria for shoulder grooving.	Version 5	05/26/09: MPCTAC 05/26/09: UMC 06/24/09: QIC
05/01/10	No criteria changes. Updated references.	Version 6	05/25/10: MPCTAC 06/23/10: QIC
05/01/11	No criteria changes. Updated references and coding.	Version 7	05/18/11: MPCTAC 06/22/11: QIC
05/01/12	Note added at end of Clinical Background Information related to a patient considering both bariatric surgery and reduction mammoplasty. References updated.	Version 8	05/16/12: MPCTAC 06/27/12: QIC
07/30/12	Off cycle review for Well Sense Health Plan. Reformatted Clinical Guideline Statement and revised references.	Version 9	08/03/12: MPCTAC 09/05/12: QIC
04/01/13	Review for effective date of 08/01/13. Revised Summary, Description of Item or Service, and Clinical Background Information sections. Revised language in introductory paragraph of Applicable	08/01/13 Version 10	04/17/13: MPCTAC 05/16/13: QIC

Breast Reduction Surgery

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## Policy Revisions History

	Coding section. Revised and added limitations. Updated criteria in Medical Policy Statement section (formerly titled Clinical Guideline Statement section). Moved definition of Schnur Sliding Scale from Clinical Background Information section to the Definitions section. Added text to gigantomastia definition. Referenced the following Plan policies: Medically Necessary, Mastopexy, Breast Reconstruction, Bariatric Surgery, Gynecomastia Surgery, and Cosmetic, Reconstructive, and Restorative Services. Updated references. Changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”		
06/01/13	Review for effective date of 09/01/13. Revised text in Medical Policy Statement section. Deleted CPT code 15877 from applicable code list.	09/01/13 Version 11	06/19/13: MPCTAC 07/18/13: QIC
04/01/14	Review for effective date 08/01/14. Revised Medical Policy Statement section. Updated the definition of the Schnur Sliding Scale and the References section.	08/01/14 Version 12	04/16/14: MPCTAC 05/14/14: QIC
04/01/15	Review for effective date 06/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Updated Summary, Definitions, and References sections. Added to the Medical Policy Statement section that preoperative photographs may be required upon request during the Plan prior authorization process.	06/01/15 Version 13	04/15/15: MPCTAC 05/13/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 14	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 06/01/16. Revised the Clinical Background	06/01/16 Version 15	04/20/16: MPCTAC 05/23/16: QIC

### Breast Reduction Surgery

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## Policy Revisions History

	Information, References, and Reference to Applicable Laws and Regulations sections.		
09/28/16	Review for effective date 11/01/16. Revised policy title and made administrative changes to clarify language related to gender.	11/01/16 Version 16	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
04/01/17	Review for effective date 05/08/17. Administrative changes made to the Medical Policy Statement section. Updated Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	05/08/17 Version 17	04/19/17: MPCTAC
05/01/18	Review for effective date 06/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, References, and Other Applicable Policies sections.	06/01/18 Version 18	05/16/18: MPCTAC
04/01/19	Review for effective date 05/01/19. Administrative changes made to the Limitations, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	05/01/19 Version 19	04/18/19: MPCTAC (electronic vote)
04/01/20	Review for effective date 07/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections.	07/01/20 Version 20	04/15/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Industry-wide update to code descriptions in the Applicable Coding section. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, and Limitations sections. Updated the policy title.	01/01/21 Version 21	Not applicable because industry-wide code changes; 12/16/20: MPCTAC review
05/01/21	Review for effective date 08/01/21. Administrative changes made to the Policy Summary, Definitions,	08/01/21 Version 22	05/19/21: MPCTAC

Breast Reduction Surgery

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## Policy Revisions History

Limitations, and References sections. Criteria revised in the Medical Policy Statement section.		
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### Last Review Date

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05/01/21

### Next Review Date

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04/01/22

### Authorizing Entity

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MPCTAC

### Other Applicable Policies

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Medical Policy - *Breast Reconstruction*, policy number OCA 3.43  
Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69  
Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12  
Medical Policy - *Gender Affirmation Surgeries*, policy number OCA 3.11  
Medical Policy - *Gynecomastia Surgery*, policy number OCA 3.48  
Medical Policy - *Mastopexy*, policy number OCA 3.717  
Medical Policy - *Medically Necessary*, policy number OCA 3.14  
Medical Policy - *Skin Substitutes in the Outpatient Setting*, policy number OCA 3.710  
Pharmacy Policy - *Egrifta*<sup>®</sup>, policy number 9.032  
Reimbursement Policy - *Ambulatory Surgical Center - Facility*, policy number SCO 4.114  
Reimbursement Policy - *Ambulatory Surgery Center*, policy number WS 4.31  
Reimbursement Policy - *Anesthesia*, policy number 4.103  
Reimbursement Policy - *Anesthesia*, policy number SCO 4.103  
Reimbursement Policy - *Anesthesia*, policy number WS 4.11  
Reimbursement Policy - *Bilateral and Multiple Procedure Reductions*, policy number 4.607  
Reimbursement Policy - *Bilateral and Multiple Procedure Reductions*, policy number SCO 4.607  
Reimbursement Policy - *Free Standing Surgical Facility Services*, policy number 4.114  
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31  
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31  
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.17  
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108

Breast Reduction Surgery

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Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy SCO 4.108

Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18

Reimbursement Policy - *Hospital*, policy number WS 4.21

Reimbursement Policy - *Inpatient Hospital*, policy number 4.110

Reimbursement Policy - *Inpatient Hospital*, policy number SCO 4.110

Reimbursement Policy - *Non-Participating Provider*, policy number WS 4.5

Reimbursement Policy - *Non-Reimbursed Codes*, policy number 4.38

Reimbursement Policy - *Non-Reimbursed Codes*, policy number WS 4.38

Reimbursement Policy - *Outpatient Hospital*, policy number 4.17

Reimbursement Policy - *Outpatient Hospital*, policy number SCO 4.17

Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number 4.608

Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number SCO 4.608

Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number WS 4.28

Reimbursement Policy - *Professional Bilateral and Multiple Procedure Reductions*, policy number WS 4.24

Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.610

Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number SCO 4.610

Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number WS 4.29

## **Reference to Applicable Laws and Regulations**

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78 FR 48164-69. Centers for Medicare & Medicaid Services (CMS). Medicare Program. Revised Process for Making National Coverage Determinations. 2013 Aug 7.

78 FR 48164-69. Federal Register. Centers for Medicare & Medicaid Services (CMS). Medicare Program. Revised Process for Making National Coverage Determinations. 2013 Aug 7.

130 CMR 410.00. Code of Massachusetts Regulations. Division of Medical Assistance. Outpatient Hospital Services.

130 CMR 415.000. Code of Massachusetts Regulations. Division of Medical Assistance. Acute Inpatient Hospital Services.

130 CMR 433.000. Code of Massachusetts Regulations. Division of Medical Assistance. Physician Services.

130 CMR 450.000. Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations.

Breast Reduction Surgery

<sup>†</sup> *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

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He-W 500. New Hampshire Code of Administrative Rules. Medical Assistance.

He-W 530.01(e). New Hampshire Code of Administrative Rules. Medical Assistance. Service Limits, Co-Payments, and Non-Covered Services. Definitions. Medically Necessary.

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RSA Chapter 417-D:2-b. New Hampshire Revised Statutes. Insurance. Women's Health Care. Reconstructive Surgery.

RSA Chapter 420-E. New Hampshire Revised Statutes. Insurance. Licensure of Medical Utilization Review Entities.

U.S. Women's Health and Cancer Right Act of 1998.

#### **Disclaimer Information: +**

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency

Breast Reduction Surgery

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policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

#### Breast Reduction Surgery

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