

# MEDICAL POLICY

<b>POLICY TITLE</b>	<b>REDUCTION MAMMOPLASTY FOR BREAST-RELATED SYMPTOMS</b>
<b>POLICY NUMBER</b>	<b>MP 1.013</b>

<b>CLINICAL BENEFIT</b>	<input type="checkbox"/> <b>MINIMIZE SAFETY RISK OR CONCERN.</b> <input type="checkbox"/> <b>MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.</b> <input type="checkbox"/> <b>ASSURE APPROPRIATE LEVEL OF CARE.</b> <input type="checkbox"/> <b>ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.</b> <input checked="" type="checkbox"/> <b>ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.</b> <input type="checkbox"/> <b>ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.</b>
<b>Effective Date:</b>	<b>7/1/2024</b>

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## I. POLICY

Reduction mammoplasty may be considered **medically necessary** when all the following are documented:

- Macromastia must be the primary cause of symptoms **AND**
- At least two of the following symptoms have been documented for a duration of 6 weeks or more:
  - Chronic breast pain due to weight of breasts
  - Intertrigo unresponsive to medical management
  - Upper back, neck, and shoulder pain
  - Backache
  - Thoracic kyphosis
  - Shoulder grooving from bra straps\*
  - Upper extremity paresthesia due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area
  - Congenital breast deformity\*

**\*Photographic documentation is required**

Reduction mammoplasty is considered a reconstructive procedure and **medically necessary** when performed on the unaffected breast following previous radical surgery for disease when the purpose is to provide symmetry with the breast on which the mastectomy has been performed (Act 51 of 1997).

Reduction mammoplasty is considered **investigational** for all other indications not meeting the above criteria as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

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***Cross-reference:***

- MP 1.004** Cosmetic and Reconstructive Surgery
- MP 1.036** Risk-Reducing Mastectomy and Risk-Reducing Bilateral Oophorectomy or Salpingo-Oophorectomy
- MP 1.103** Reconstructive Breast Surgery Including Management of Breast Implants, External Breast Prosthesis and Post Mastectomy Bras
- MP 1.129** Surgical Treatment of Gynecomastia

## II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

**FEP PPO:** Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: <https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>.

## III. DESCRIPTION/BACKGROUND

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### **MACROMASTIA**

Macromastia, or gigantomastia, is a condition that describes breast hyperplasia or hypertrophy. Macromastia may result in clinical symptoms such as shoulder, neck, or back pain, or recurrent intertrigo in the mammary folds. In addition, macromastia may be associated with psychosocial or emotional disturbances related to the large breast size. Reduction mammoplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or to relieve the associated clinical symptoms.

The presence of shoulder, neck, or back pain is the most common stated *medical* rationale for reduction mammoplasty. However, because these symptoms are subjective, some insurers have attempted to quantify the need for reduction mammoplasty using specified amounts of breast tissue to be resected or ideal body weight parameters. Based on the recommendations from the American Society of Plastic Surgeons, these indicators are no longer used as criteria (see [Rationale](#) below).

### **Treatment**

Reduction mammoplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or relieve the associated clinical symptoms.

While literature searches have identified many articles that discuss the surgical technique of reduction mammoplasty and have documented that reduction mammoplasty is associated with relief of physical and psychosocial symptoms, an important issue is whether reduction mammoplasty is a functional need or cosmetic. For some patients, the presence of medical indications is clear-cut: clear documentation of recurrent intertrigo or ulceration secondary to

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shoulder grooving. For some patients, the documentation differentiating between a cosmetic and a medically necessary procedure will be unclear. Criteria for medically necessary reduction mammoplasty are not well-addressed in the published medical literature.

Some protocols on the medical necessity of reduction mammoplasty are based on the weight of removed breast tissue. The basis of weight criteria is not related to the outcomes of surgery, but to surgeons retrospectively classifying cases as cosmetic or medically necessary. Schnur et al (1991) at the request of third-party payers, developed a sliding scale. This scale was based on survey responses from 92 of 200 solicited plastic surgeons, who reported the height, weight, and amount of breast tissue removed from each a breast from the last 15 to 20 reduction mammoplasties they had performed. Surgeons were also asked if the procedures were performed for cosmetic or medically necessary reasons. The data were then used to create a chart relating the body surface area, and the cutoff weight of breast tissue removed that differentiated cosmetic and medically necessary procedures. Based on their estimates, those with a breast tissue removed weight above the 22<sup>nd</sup> percentile likely had the procedure for medical reasons, while those below the 5<sup>th</sup> percentile likely had the procedure performed for cosmetic reasons; those falling between the cutpoints had the procedure performed for mixed reasons.

Schnur (1999) reviewed the use of the sliding scale as a coverage criterion and reported that, while many payers had adopted it, many had also misused it. Schnur pointed out that if a payer used weight of resected tissue as a coverage criterion, then if the weight fell below the 5<sup>th</sup> percentile, the reduction mammoplasty would be considered cosmetic; if above the 22<sup>nd</sup> percentile, it would be considered medically necessary; and if between these cutpoints, it would be considered on a case-by-case basis. Schnur also questioned the frequent requirement that a woman is within 20% of her ideal body weight. While weight loss might relieve symptoms, durable weight loss is notoriously difficult and might be unrealistic in many cases.

Per the American Society of Plastic Surgeons,

“Symptomatic breast hypertrophy is defined as a syndrome of persistent neck and shoulder pain, painful shoulder grooving from brassiere straps, chronic intertriginous rash of the inframammary fold, and frequent episodes of headache, backache, and neuropathies caused by heavy breasts caused by an increase in the volume and weight of breast tissue beyond normal proportions. The justification for reduction mammoplasty should be based on the probability of relieving the clinical signs and symptoms of symptomatic breast hypertrophy. Because it is difficult to determine the size at which breast enlargement becomes pathologic in any individual, it is the position of the American Society of Plastic Surgeons that the definition of symptomatic breast hypertrophy should focus on the degree of symptomatology, not the degree of breast hypertrophy present (cup size or amount of tissue removed).”

### REGULATORY STATUS

Reduction mammoplasty is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

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### IV. Rationale

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#### SUMMARY OF EVIDENCE

For individuals who have symptomatic macromastia who receive reduction mammoplasty, the evidence includes systematic reviews, randomized controlled trials, cohort studies, and case series. Relevant outcomes are symptoms and functional outcomes. Studies have indicated that reduction mammoplasty is effective at decreasing breast-related symptoms such as pain and discomfort. There is also evidence that functional limitations related to breast hypertrophy are improved after reduction mammoplasty. These outcomes are achieved with acceptable complication rates. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Per recommendations from the American Society of Plastic Surgeons,

“According to the findings of a Level II, prospective study, non-surgical therapies, such as support bras, physical therapy, exercise, and medications, have been found to be ineffective in providing permanent relief of breast hypertrophy symptoms. To date, there are no studies published affirming the cost effectiveness of conservative measures as a first line therapy for the treatment of symptomatic breast hypertrophy. The scientific evidence from high quality, randomized controlled trials indicates that reduction mammoplasty is effective at reducing symptomatic breast hypertrophy-related symptoms and improving quality of life. Level I Evidence indicates that reduction mammoplasty is an effective treatment for patients with symptomatic breast hypertrophy. Resection weight thresholds are often used as a determinant for insurance coverage criteria. While a few studies have attempted to validate the relationship between resection weight and medical necessity, currently no study exists that provides a sound scientific rationale for this theory. The commonly used Schnur Sliding Scale suggests that resection weights above the 22<sup>nd</sup> percentile should be regarded as reconstructive, while resection weights falling below the fifth percentile should be deemed cosmetic. However, from a scientific standpoint, the basis for developing this scale is flawed. The Schnur scale recommendations are derived from a survey that asked plastic surgeons their perceptions of their patients’ motivations for reduction mammoplasty (i.e., reconstructive, or cosmetic). This survey study design, based on surveyed perception of others, is susceptible to significant bias and does not meet the inclusion criteria for being a moderate or high-quality study on the ASPS Level of Evidence Rating Scale. Schnur himself has even challenged insurance carriers’ misuse of the scale and has indicated that the scale should no longer be used as criteria for insurance coverage. The Seitchik Formula is also cited by some third-party payers. Seitchik’s retrospective study, “Reduction Mamaplasty: Criteria for Insurance Coverage” sought to determine the relationship between body weight and resection weight. However, Seitchik concluded that “I cannot derive a useful formula to determine, in advance, which patients will receive symptomatic, and therefore compensable relief from reduction mammoplasty”. Based on the limited study findings, Seitchik offered his own formula based on personal recommendation, not scientific data. Since the Schnur sliding scale and Seitchik formula lack scientific rigor and validity, they should not be used as criteria for approval of insurance coverage. Evidence indicates that women, across a wide range of breast sizes, experience similar benefits from reduction mammoplasty. According to two prospective studies, women of varying breast sizes, experience similar preoperative symptoms and similar postoperative relief and quality of life improvement

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regardless of the total resection volume. Level II Evidence indicates that resection volume is not correlated to the degree of postoperative symptom relief.”

### V. DEFINITIONS

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**Act 51 of 1997 – The Mastectomy Act:** PA mandate that prohibits health insurance companies from requiring mastectomies to be performed on an outpatient basis. Other requirements include coverage for: One home health visit within 48 hours after discharge when the discharge is within 48 hours of the admission for the mastectomy; Reconstructive surgery, including surgery to re-establish symmetry and mastectomy –related prosthetic devices.

**Cosmetic surgery:** An elective procedure performed primarily to change a person’s appearance by surgically altering a physical characteristic that does not prohibit normal function but is considered unpleasant or unsightly.

**Intertrigo:** A superficial dermatitis occurring on apposed skin surfaces, such as the axillae, creases of the neck, intergluteal fold, groin, between the toes and beneath pendulous breasts, with obesity being a predisposing factor, caused by moisture, friction, warmth and sweat retention and characterized by erythema, maceration, burning, itching and sometimes erosions, fissures and exudations and secondary infections.

**Reconstructive surgery:** A procedure performed to improve or correct a functional impairment, restore a bodily function, or correct a deformity resulting from birth defect or accidental injury. The fact that a member might suffer psychological consequences from a deformity does not, in the absence of bodily functional impairment, qualify surgery as being reconstructive surgery.

### VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member’s health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member’s health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member’s health benefit plan for information or contact Capital Blue Cross for benefit information.

### VII. DISCLAIMER

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*Capital Blue Cross’ medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. If a provider or a*

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*member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.*

### VIII. CODING INFORMATION

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**Note:** This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

#### Covered when medically necessary:

Procedure Codes							
19318							

ICD-10-CM Diagnosis Codes	Description
G54.0	Brachial plexus disorders
G56.40	Causalgia of unspecified upper limb
G56.41	Causalgia of right upper limb
G56.42	Causalgia of left upper limb
G56.43	Causalgia of bilateral upper limbs
L24.A0	Irritant contact dermatitis due to friction or contact with body fluids, unspecified
L24.A9	Irritant contact dermatitis due friction or contact with other specified body fluids
L30.4	Erythema intertrigo
L98.491	Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.519	Pain in unspecified shoulder
M40.04	Postural kyphosis, thoracic region
M53.83	Other specified dorsopathies, cervicothoracic region
M54.2	Cervicalgia
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M95.4	Acquired deformity of chest and rib
N62	Hypertrophy of breast
N64.4	Mastodynia



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<b>ICD-10-CM Diagnosis Codes</b>	<b>Description</b>
N65.1	Disproportion of reconstructed breast
Q83.8	Other congenital malformations of breast

### IX. REFERENCES

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**X. POLICY HISTORY**

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<b>MP 1.013</b>	<b>02/26/2020 Consensus Review.</b> Policy statement unchanged. Policy Guideline added. Background and references updated. Coding updated.
	<b>03/23/2021 Minor Review.</b> Policy statement unchanged. References updated. The following section was moved from policy guidelines section to policy statement section:  The presence of shoulder, neck, or back pain is the most common stated <i>medical</i> rationale for reduction mammoplasty. However, because these symptoms and others may be subjective, Plans have implemented various patient selection criteria designed to be more objective. They include:



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	<ul style="list-style-type: none"> <li>• Use of photographs, providing a visual documentation of breast size or documenting the presence of shoulder grooving, an indication that the breast weight results in grooving of the bra straps on the shoulder.</li> <li>• Requirement of a specified amount of breast tissue to be respected, commonly 500 to 600 grams per breast.</li> <li>• Use of the Schnur Sliding Scale, which suggests a minimum amount of breast tissue to be removed for the procedure to be considered medically necessary, based on the patient's body surface area. Some Plans may use the Schnur Sliding Scale only for weight of resected tissue that falls below 500 to 600 grams.</li> </ul> <p>Requirement that the patient must be within 20% of ideal body weight to eliminate the possibility that obesity is contributing to the symptoms of neck or back pain.</p>
	<b>09/08/2021 Administrative Update.</b> New codes L24.A0 and L24.A9 added. Effective 10/1/2021
	<p><b>06/06/2022 Minor Review.</b> Criteria changed to</p> <ul style="list-style-type: none"> <li>• Macromastia must be the primary cause of symptoms <b>AND</b></li> <li>• At least two of the following symptoms have been documented for a duration of 6 weeks or more: <ul style="list-style-type: none"> <li>○ Chronic breast pain due to weight of breasts</li> <li>○ Intertrigo unresponsive to medical management</li> <li>○ Upper back, neck, and shoulder pain</li> <li>○ Backache</li> <li>○ Thoracic kyphosis</li> <li>○ Shoulder grooving from bra straps*</li> <li>○ Upper extremity paresthesia due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area</li> <li>○ Congenital breast deformity*</li> </ul> </li> </ul> <p>Policy Guidelines removed. Background and Rationale extensively revised. References added. Added the following ICD10 codes to policy – G54.0, G56.40, G56.41, G56.42, G56.43, M40.04, M53.83, M54.2, M54.6, M95.4, N64.4, Q83.8. FEP language updated. References added.</p>
	<b>04/11/2023 Consensus Review.</b> No change to policy statement. Background and References updated.
	<b>03/29/2024 Consensus Review.</b> No change to policy statement. Cross Referenced policies updated. References added.

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