Medical Policy:
Prior Authorization Criteria:
Reduction Mammoplasty (Commercial)

POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
MG.MM.SU.01eC8v2	**04/09/2021**	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare 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). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan 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 ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions

Cometic 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 Affirming/Reassignment Surgery

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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.

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

* BSA (m2) = ([height (cm) x weight (kg)]/ 3600)^{½}; BSA calculator may be found at http://www.calculatorpro.com/body-surface- area-calculator

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Limitation/Exclusion

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 Codes

19316	Mastopexy
19318	~~Reduction~~ Breast mammaplasty (Revised 01/01/2021)

Applicable ICD-10 Diagnosis Codes

N62	Hypertrophy of breast

References

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third Party Payers: Reduction Mammaplasty. 2017. http://www.plasticsurgery.org/for-medical-professionals/legislation-and-advocacy/health-policy- resources/recommended-insurance-coverage-criteria.html. Accessed April 12, 2021.

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Specialty-matched clinical peer review

Revision history

DATE	REVISION
07/15/2021	Retired MCG criteria for this service Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth