

***Reduction Mammoplasty (Mammoplasty) Coverage Guidelines
for Female Members***

Origination: 11/26/96	Revised: 05/20/09	Annual Review: 12/15/11
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Purpose:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Reduction Mammoplasty (for Female Members) in order to determine inclusion in the benefit plan.

Compliance Status

- Centers for Medicare & Medicaid Services (CMS)

Recommendation:

A recommendation was made by the MTAC following discussion by committee members based on current literature:

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

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Recommendation, continued:

Eligibility Criteria

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

CPT Code: 19318 Reduction Mammoplasty (Mammoplasty)

- 1.0 Reduction mammoplasty (mammoplasty) is indicated for *macromastia* when **ALL** of the following are present:
 - 1.1 Large breast size in relation to body, requiring removal of a minimum of 500 g of breast tissue or supernatant fat from each breast (500 g is based on the body surface area of 1.66m² of an average 5'2" female at her maximum Ideal Body Weight; refer to Metropolitan Life Ideal Body Weight Chart);
 - 1.2 Signs and symptoms that cause significant interference with daily life which are directly attributable to large breast size, for at least one year, which may include³:
 - 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;

***Reduction Mammoplasty (Mammoplasty) Coverage Guidelines
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Recommendation, continued:

Eligibility Criteria, continued

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

- 1.0 Reduction mammoplasty (mammoplasty) is indicated for *macromastia* when **ALL** of the following are present, continued:
 - 1.3 Documented history of failed course of conservative treatment for relevant presenting symptoms, which includes³:
 - 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 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.

These Coverage Guidelines apply to Medicare Members (female gender) for Indications and Limitations of Coverage and/or Medical Necessity²

Considerable attention has been given to the amount of breast tissue removed in differentiating between cosmetic and medically necessary reduction mammoplasty. Criteria for arbitrary minimum weight of breast tissue removed does not consistently reflect the consequences of mammary hypertrophy in individuals with a unique body habitus. The available literature is replete with minimum weights for resected mammary tissue. However, there is very little information available as to the scientific basis for these values. Therefore, this policy incorporates the signs and/or symptoms in indications and limitations (above) for the determination of medically reasonable and necessary reduction mammoplasty. Medical review and coverage determinations will be based upon this assessment approach.

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Recommendation, continued:

Eligibility Criteria, continued

These Coverage Guidelines apply to Medicare Members (female gender) for Indications and Limitations of Coverage and/or Medical Necessity², continued

- 1.0 Florida Medicare will consider Reduction Mammoplasty reasonable and necessary when performed in the presence of significantly enlarged breast **and** the presence of at least one (1) of the following:
 - 1.1 Documentation that suggests a history of back and/or shoulder pain which adversely affects activities of daily living (ADLs) unrelieved by conservative analgesia (e.g., such as NSAID, compresses, massage, etc.), supportive measures (e.g., such as garments, back brace, etc.), physical therapy, and/or correction of obesity;
 - 1.2 Documentation that suggests a history of significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity;
 - 1.3 Signs and symptoms of ulnar paresthesias (e.g., evidenced by nerve conduction studies), cervicalgia, torticollis, and acquired kyphosis;
 - 1.4 Signs and symptoms of intertriginous maceration or infection of the inframammary (e.g., hyperpigmentation, bleeding, chronic moisture, and evidence of skin breakdown) skin refractory to dermatologic measures;
 - 1.5 Signs and symptoms of shoulder grooving with skin irritation (e.g., areas of excoriation and breakdown) by supporting garment;
 - 1.6 Florida Medicare will consider reduction mammoplasty reasonable and necessary when performed to achieve symmetry following removal and/or reconstruction of a breast due to malignancy.

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:
 - 2.1 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

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1999 METROPOLITAN HEIGHT AND WEIGHT TABLES FOR WOMEN
According to Frame, Ages 25-59
Weight in Pounds (In Indoor Clothing)*

HEIGHT		SMALL	MEDIUM	LARGE
(In Shoes)+		FRAME	FRAME	FRAME
Feet	Inches			
4	10	102-111	109-121	118-131
4	11	103-113	111-123	120-134
5	0	104-115	113-126	122-137
5	1	106-118	115-129	125-140
5	2	108-121	118-132	128-143
5	3	111-124	121-135	131-147
5	4	114-127	124-138	134-151
5	5	117-130	127-141	137-155
5	6	120-133	130-144	140-159
5	7	123-136	133-147	143-163
5	8	126-139	136-150	146-167
5	9	129-142	139-153	149-170
5	10	132-145	142-156	152-173
5	11	135-148	145-159	155-176
6	0	138-151	148-162	158-179

- Indoor clothing weighing 5 pounds for men and 3 pounds for women.

+ Shoes with 1-inch heels

Source of basic data Build Study, 1979. Society of Actuaries and Association of Life Insurance Medical Directors of America, 1980.

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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 Mammoplasty (Mammoplasty) (Women's Health) ACG: A-0274(AC)*.
4. *American Society of Plastic Surgeons (ASPS), Reduction Mammoplasty*. ASPS Recommended Coverage Criteria for Third Party Payers. Arlington Heights, IL, ASPS: March 9, 2002.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans 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 Health Plans 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.