Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Reduction Mammoplasty

Policy Number: PG0054
Last Review: 10/01/2023

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

X Professional
X Facility

DESCRIPTION:

Reduction mammoplasty or breast reduction surgery involves removal of skin, fat, and breast tissue to reduce breast mass. Breast reduction surgery is performed when excess breast mass and weight causes medical problems such as sub-mammary intertrigo (an inflammatory condition causing redness, burning, itching, skin disintegration and cracking underneath the breast), shoulder grooving, back, neck and shoulder pain, or thoracic outlet syndrome, which can lead to pain and loss of feeling in the arms or hands.

Reduction mammaplasty is performed to reduce the size of the breast and help ameliorate symptoms caused by the hypertrophy and to reduce the size of a normal breast to bring it into symmetry with a breast reconstructed after cancer surgery.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

- **Reduction mammoplasty (19318) requires prior authorization for all product lines.**

Related medical policies

- **Mastectomy for Gynecomastia, PG0221**
- **Breast Reconstruction Services, PG0144**
- **Cosmetic and Reconstructive Surgery, PG0104**

Gender Reassignment Surgery, PG0311

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Coverage for reduction mammoplasty is dependent on benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit and may be governed by state and/or federal mandates. Under many benefit plans, reduction mammoplasty is not covered when performed solely for the purpose of altering appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

Paramount considers reduction mammoplasty (19318) medically necessary when ALL the following criteria have been met:

1. The individual is at least 18 years of age or breasts are fully grown (i.e., breast size stable for approximately one year).

2. Macromastia is causing at least ONE of the following conditions/symptoms with documented failure of at least one continuous three-month trial of appropriate conservative medical management
    - Pain in the neck, shoulders, upper back and/or ulnar nerve palsy for which no other etiology has been found on appropriate evaluation
    - Skin breakdown (severe soft tissue infection, tissue necrosis, ulceration hemorrhage) intertrigo, dermatitis, eczema, or hidradenitis at the inframammary fold
        - Note: Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold in and of themselves are not considered medically necessary indications for reduction mammoplasty. The condition not only must be unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of 6 months or longer, but also must satisfy medical necessity indications

3. The potential causes of the above conditions/symptoms, other than breast size (e.g., intervertebral disc disorder, arthritis, and rheumatologic disorders) have been evaluated and ruled out OR breast size has been documented as exacerbating the underlying condition (e.g., intervertebral disc disorder, arthritis, and rheumatologic disorders) contributing to symptoms.

4. Mammogram performed within 12 calendar months prior to the date of the scheduled procedure negative for suspected cancer (applicable to individuals 40 years of age or older without a known breast cancer diagnosis).

5. Functional impairment adversely affecting activities of daily living due to severe back, neck and/or shoulder pain or upper extremity paresthesia directly attributable to macromastia, refractory to conservative treatment and no other etiology has been found on medical evaluation

6. Preoperative photographs confirm the presence of BOTH of the following:
    - significant breast hypertrophy
    - shoulder grooving from bra straps and/or intertrigo if stated to be present

7. Average weight of tissue planned to be removed in each breast is above the 22nd percentile on the Schnur Sliding Scale based on the individual's body surface area (BSA).

    Considerable attention has been given to the amount of breast tissue removed in differentiating between cosmetic and medically necessary reduction mammoplasty. To be considered a non-cosmetic procedure it is expected that at least a minimal amount of breast tissue will be removed. Yet, arbitrary minimum weight breast tissue removed criteria do not consistently reflect the consequences of mammary hypertrophy in individuals with a unique body habitus. There are wide variations in the range of height, weight, and associated breast size that cause symptoms. The amount of tissue that must be removed in order to relieve symptoms will vary and depend upon these variations.

    The following are guidelines (not rules) that address the patient's body surface area (BSA) and the amount of breast tissue removed.

Schnur Sliding Scale
Body Surface Area and Cutoff Weight of Breast Tissue Removed

Breast Reduction (gm)		
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

If only one breast meets the Schnur scale criteria, and all other criteria for breast reduction are met, breast tissue may be removed from the other breast in order to achieve symmetry.

Conservative treatment includes 3 consecutive months of medical management, including at least one of the following:

- Chiropractic care or osteopathic manipulative treatment; or
- Medically prescribed exercise regimen; or
- Medically supervised weight loss program; or
- Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs) interventions and/or muscle relaxants; or
- Dermatologic therapy of ulcers, necrosis, and refractory infection, or
- Physical therapy/exercises/posturing maneuvers, or
- Supportive devices (e.g., proper bra support, wide bra straps).

Paramount does not cover reduction mammoplasty for either of the following indications because it is considered cosmetic in nature and not medically necessary:

- Surgery is being performed to treat psychological symptomatology or psychosocial complaints, in the absence of significant physical, objective signs.

Surgery is being performed for the sole purpose of improving appearance, i.e., cosmetic surgery to reshape the breasts to improve appearance.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODE	
19318	Reduction mammoplasty
ICD-10 CODE	
N62	Hypertrophy of breast [gynecomastia, hypertrophy of breast NOS, massive pubertal hypertrophy of breast]

N64.81	Ptosis of breast
N64.89	Other specified disorders of breast
N65.1	Disproportion of reconstructed breast

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 12/11/2014

Date	Explanation & Changes
02/11/2014	• Policy created to reflect most current clinical evidence per Medical Policy Steering Committee
06/09/2015	• Homegrown criteria will now be followed replacing InterQual criteria • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
06/24/2016	• Policy reviewed and updated to reflect most current clinical evidence per TAWG
11/23/2016	• Gender verbiage changes completed per Meaningful Access Section 1557 of the Affordable Care Act
02/13/2018	• Added ICD-10 code N64.89 • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
12/14/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/03/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
10/01/2023	• Medical Policy updated to reflect the most current clinical evidence • Updated diagnosis N64.89 description and added diagnosis N62, N64.81 and N65.1
02/01/2024	• Medical policy placed on the new Paramount Medical Policy format

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) alphabetical index.

Centers for Medicare and Medicaid Services (CMS). Local Coverage Determinations (LCDs) alphabetical index.

National Comprehensive Cancer Network® (NCCN). NCCN GUIDELINES™ Clinical Practice Guidelines in Oncology™.

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/

Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review