Minuteman Health

Clinical Review Criteria Related to Female Reduction Mammoplasty and Breast Reconstruction

I.Criteria for Approval

A. Minuteman Health Insurance (MHI) considers Reduction Mammoplasty (CPT 19318) to be medically necessary for members over the age of 18 who meet the following criteria:

1. Patient must either have *one* of the syndromes listed in section B. *or* meet *both* clinical criteria specified in section C.

B. **Syndromes** (any *one* of the following):

1. Poland syndrome[1] (Note: Treatment of this syndrome often requires augmentation on one side and some reduction on the other to improve symmetry.)

2. Juvenile macromastia[2]

3. High-risk gravid macromastia[3]

C. **Clinical Criteria** (*both* of the following):

1. Symptoms (*one* of the following):

a. Physical condition severe enough to warrant surgery (e.g., risk of sternal wound dehiscence)

b. Pain severe enough to warrant surgery and attributable to significant macromastia as defined by the tissue weight criteria (e.g., intractable

[1] Unilateral hypoplasia of the pectoral muscle and breast.
[2] A rare, rapid, and massive enlargement of one or both breasts afflicting girls 11 to 14 years of age. (Only 70 cases of severe juvenile breast hypertrophy have been documented in the literature.) 1,500-4,000 extra grams of tissue per breast may develop within three to six months. A benefit exception will be considered in eligible cases as recommended by the pediatrician, plastic surgeon, and the child's parents.
[3] An enlargement of the breasts during pregnancy that causes stretching and fracturing of the dermis, typically observed in the third or fourth month of gestation. The condition occurs in one of every 25,000 to 100,000 pregnancies. Conservative therapy (e.g., breast support, bed rest, analgesics) is the treatment of choice for gestational macromastia. If conservative therapy is unsuccessful, a benefit exception will be considered for cases identified by an obstetrician as high risk for hemorrhaging and sepsis. The decision to recommend surgery will be made between the patient, her obstetrician, and the plastic surgeon.

intertrigo, bra strap grooving, back pain or shoulder pain unrelieved by conservative analgesia or physical therapy)

2. Recommended guidelines for consideration of reduction mammoplasty:

   a) Tissue weight to be removed from each breast**:**

Body surface area and cutoff weight of average breast tissue removed

Body Surface Area (m2)	Average grams of tissue per breast to be removed
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068

2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662
2.60	1806
2.65	1972
2.70	2154
2.75	2352
2.80	2568
2.85	2804
2.90	3061
2.95	3343
3.00	3650
3.05	3985
3.10	4351
3.15	4750
3.20	5186
3.25	5663
3.30	6182
3.35	6750
3.40	7369
3.45	8045
3.50	8783
3.55	9589
3.60	10468
3.65	11428
3.70	12476
3.75	13619
3.80	14867

3.85	16230
3.90	17717
3.95	19340
4.00	21112
4.05	23045
4.10	25156
4.15	27459
4.20	29972
4.25	32716
4.30	35710
4.35	38977
4.40	42543
4.45	46435
4.50	50682
4.55	55316
4.60	60374
4.65	65893
4.70	71915
4.75	78487
4.80	85658

3. Simplified formula for calculation of body surface area:

   a) (BSA (in m^2) = [height (cm)] $^{0.718}$ X [weight (kg)] $^{0.427}$ X .0

II. Required Documentation

A. Letter of medical necessity or office notes documenting clinical indications:

1. Height and weight

2. Body surface area (BSA)

3. Clinical evaluation of signs and/or symptoms

4. Therapies attempted and responses to those therapies

5. Photographs

III.What is Not Covered

A. Cosmetic surgery

B. Correction of nipple inversion

C. Absence of persistent signs or symptoms

D. Surgery on anyone under age 18

E. Failure to satisfy the minimum criteria defined above

F. Autologous fat grafting

G. Liposuction

H. Mastopexy (except following a mastectomy)

I. Surgical repair of inverted nipple

***** For male gynecomastia please refer to MHI policy Surgical Treatment of Gynecomastia**

IV.CPT/ ICD-10/ HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

ICD-10 Code

N62 Hypertrophy of breast

N60-65 Disorders of breast

CPT Code

19318 Reduction Mammoplasty

V.References

NCQA Standard, UM2, Clinical Criteria for Utilization Management Decisions, Element A

Centers for Medicare & Medicaid Services, LCD for Reduction Mammoplasty (L34186), http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=28222&lcd_version=2&show=all Last Accessed 12/23/16)

Schnur, Paul L, et al., "Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?" Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7. (Last Accessed 12/23/16)

The Schnur Sliding Scale Chart, American Society of Plastic Surgeons (ASPS), "ASPS Recommended Insurance Coverage Criteria for Third Party Payers: Reduction Mammoplasty," Approved by the ASPS Board of Directors, March 9, 2002 http://www.bcbst.com/MPManual/The_Schnur_Sliding_Scale_chart.htm (Last Accessed 12/23/16)

Chadbourne, MD, Elenie B. et al, "Clinical Outcomes in Reduction Mammoplasty: A Systematic Review and Meta-analysis of Published Studies," Mayo Clin Proc. 2001; 76:503-510

Espinosa-de-los-Monteros, MD, Antonio "Breast Reduction, Lejour," eMedicine.com, Inc., September 30, 2009, http://www.emedicine.com/plastic/topic148.htm#section~author_information (Last Accessed 12/23/16)

Singh KA, Losken A. Additional benefits of reduction mammaplasty: a systematic review of the literature. *Plast Reconstr Surg.* Mar 2012; 129(3):562-570. PMID 22090252 (Last Accessed 12/23/16)

VI.Summary of Changes

04/13/2017: no changes

06/29/2017:

- Added medical guideline disclaimer

- Under III., What is not covered: removed F. Reduction mammoplasty for male Gynecomastia is not covered for HMO, PPO, and POS plans as per the individual member's benefit plan.
- Added the following disclaimer under III: *** **For male gynecomastia please refer to MHI policy Surgical Treatment of Gynecomastia**

VII.Review Dates

HNE Review Dates: 11/12/13, 11/11/14, 11/10/15, 4/12/16, 04/04/2017,
MHI Review Dates: 1/1/2014, 10/23/2014, 1/16/2015, 2/2/2016, 4/21/2016, 04/13/2017, 06/29/2017

Medical Guideline Disclaimer

The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation 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). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a 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 Minuteman. If there is a discrepancy between this policy and a member's benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.