Reduction Mammoplasty for Macromastia in the Female

Policy Number: NMP490
Effective Date*: June 2004
Updated: April 2016

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

For Medicaid Plans: Please refer to the appropriate State’s Medicaid manual(s), publication(s), citation(s), and documented guidance for coverage criteria and benefit guidelines prior to applying Health Net Medical Policies

The Centers for Medicare & Medicaid Services (CMS)
For Medicare Advantage members please refer to the following for coverage guidelines first:

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Instructions
- Medicare NCDs and National Coverage Manuals apply to ALL Medicare members in ALL regions.
- Medicare LCDs and Articles apply to members in specific regions. To access your specific region, select the link provided under “Reference/Website” and follow the search instructions. Enter the topic and your specific state to find the coverage determinations for your region. *Note: Health Net must follow local coverage determinations (LCDs) of Medicare Administration Contractors (MACs) located...
outside their service area when those MACs have exclusive coverage of an item or service. (CMS Manual Chapter 4 Section 90.2)

- If more than one source is checked, you need to access all sources as, on occasion, an LCD or article contains additional coverage information than contained in the NCD or National Coverage Manual.
- If there is no NCD, National Coverage Manual or region specific LCD/Article, follow the Health Net Hierarchy of Medical Resources for guidance.

**Current Policy Statement**

Health Net, Inc. considers reduction mammoplasty for macromastia (excessively large, pendulous breasts) medically necessary in females when all of the following non-cosmetic criteria are met:

1. The patient is 16 years of age or older, has a “D” cup size or larger and maturation of the breasts is complete as evidenced by the fact that the patient’s bra size has not changed in the past two years; and

2. Patient has large, heavy breasts and has at least one of the following:

   - Postural upper backache (Patient feels that she has to maintain an uncomfortable posture to balance her heavy breasts.)*, shoulder and/or neck pain (not lower back pain), not related to other causes (e.g., poor posture, acute strains, poor lifting techniques), significantly interfering with activities of daily living (ADL) over the last 12 months** and unresponsive to both of the following, as documented in serial chart notes from provider(s) other than the requesting surgeon:
     
     → Supportive devices (e.g., proper bra support, wide bra straps), and
     
     → A trial of medications (analgesics or non-steroidal anti-inflammatory drugs [NSAIDS], if not contraindicated) for at least 6 weeks.

   - Severe occipital headaches associated with neck and upper back pain with cervical spine x-rays showing no other causes for neck and shoulder pain; or

   - Ulnar nerve compression syndrome with documented parasthesia secondary to coracoid process descent due to the weight of the breasts being transferred to the shoulder strap area; or

   - Severe intertrigo (chafing under the breasts) unresponsive to at least 6 weeks of medical management (e.g., good hygiene, culture-specific antibiotics, dressings), as documented in serial chart notes.

     → **Important Note: Serial chart notes must document these severe and persistent symptoms for 12 months that significantly interfere with ADL, indicating the nature of symptom, treatment of symptom and response to treatment. Notes must document how symptoms interfere with activities of daily living.**
** Additional Note: Signs and symptoms must be documented in detail in the progress notes by a physician other than the one performing the surgery (primary care physician or specialist). The notes must state that there is a reasonable probability that the member’s symptoms are directly related to the macromastia as reflected by multiple office visits and that reduction mammoplasty is likely to result in improvement of the chronic pain.

3. Color photographs (not black and white photos or faxes) must be submitted for review to document any one of the following:

   - Severe breast hypertrophy (shoulder to waist - front and lateral views); or
   - Severe, inframammary intertrigo unresponsive to conservative therapy

**Note:** A mammogram performed in the 2 years before the scheduled surgery for women 40 years of age or older is required.

**Gigantomastia of Pregnancy**

Health Net, Inc. considers reduction mammoplasty for gigantomastia of pregnancy medically necessary when accompanied by any of the following complications and when delivery is not imminent:

1. Ulceration of breast tissue; or
2. Massive infection; or
3. Tissue necrosis with slough; or
4. Significant hemorrhage.

Health Net, Inc. considers reduction mammoplasty not medically necessary for any of the following, since there is no current ongoing peer-reviewed literature to support them:

1. Fibrocystic disease of the breasts
2. Cystic breast infections (polycystic mastitis)
3. Treatment for obesity
4. Reduction mammoplasty performed solely for cosmetic purposes
5. Mastopexy surgery (resuspending breast) for breast ptosis (drooping breast)
6. For the primary purpose of reducing breast cancer risk

**Codes Related To This Policy**

**NOTE:**
The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit documents and medical necessity criteria. This list of codes may not be all inclusive.
On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures have been replaced by ICD-10 code sets.

**ICD-9 Codes**
(List may not be all-inclusive)
611.1 Hypertrophy of breast
719.41 Pain in shoulder region

**ICD-10 Codes**
N62 Hypertrophy of breast
M25.511-M25.519 Pain in shoulder

**CPT Codes**
19318 Reduction mammaplasty

**HCPCS Codes**
N/A

**Scientific Rationale – Update April 2015**
Nelson et al (2014) analyzed population data from the 2005-2010 American College of Surgeons National Surgical Quality Improvement Program database to investigate effects of age on 30-day surgical outcomes for reduction mammaplasty with the hope of improving patient care, counseling, and risk stratification. Overall, 3537 patients were included in the analysis. Outcome variables included 30-day postoperative major surgical, medical, and wound complications. Patients were initially stratified into 2 groups: <60 years and ≥60 years. The World Health Organization defines age >60 years as elderly. The authors then performed a subgroup analysis, further stratifying the younger cohort into <50 years and 50-60 years of age. Univariate analysis was performed to assess the dependency of preoperative factors on surgical outcomes (P < .05). Of the 3547 patients, 3050 were <60 years of age (39.7 ± 11.8 years) and 487 were ≥60 years of age (65.1 ± 4.7 years). A total of 182 thirty-day postoperative surgical complications were documented. Stratifying patients into 2 age groups did not reveal an association between age and any surgical complication (P = .26). The authors concluded this population-level analysis of reduction mammaplasty indicated that, with proper patient selection, the procedure can be performed safely on older patients.

Nelson et al (2014) performed a population level analysis in an effort to determine the impact of obesity on early complications after reduction mammaplasty. This study examined the 2005-2011 NSQIP datasets and identified all patients who underwent reduction mammaplasty. Patients were then categorized according to the World Health Organization obesity classification. Demographics, comorbidities, and perioperative risk factors were identified among the NSQIP variables. Data was then analyzed for surgical complications, wound complications, and medical complications within 30 days of surgery. In total, 4545 patients were identified; 54.4% of patients were obese (BMI > 30 kg/m(2)), of which 1308 (28.8%) were Class I (BMI = 30-34.9 kg/m(2)), 686 (15.1%) were Class II (BMI = 35-39.9 kg/m(2)), and 439 (9.7%) were Class III (BMI > 40 kg/m(2)). The presence of comorbid conditions increased across obesity classifications (p < 0.001), with significant differences noted in all cohort comparisons except when comparing class I to class II (p = 0.12). Early complications were rare (6.1%), with superficial skin and soft tissue infections.
accounting for 45.8% of complications. Examining any complication, a significant increase was noted with increasing obesity class (p < 0.001). This was further isolated when comparing morbidly obese patients to non-obese (p < 0.001), class I (p < 0.001), and class II (p = 0.01) patients. This population-wide analysis, has demonstrated that increasing obesity class is associated with increased early postoperative complications. Morbidly obese patients are at the highest risk, with complications occurring in nearly 12% of this cohort.

Fisher et al (2014) investigated predictors of postoperative complications following reduction mammoplasty using the National Surgery Quality Improvement Program (NSQIP) data sets. The 2005-2010 American College of Surgeons NSQIP databases were reviewed to identify primary encounters for reduction mammoplasty using Current Procedural Terminology code 19318. Two complication types were recorded: major complications (deep infection and return to operating room) and any complication (all surgical complications). Preoperative patient factors and comorbidities, as well as intraoperative variables, were assessed. A multivariate regression analysis was used to identify independent predictors of complications. A total of 3538 patients were identified with an average age of 43 years and body mass index of 31.6 kg/m(2). Most patients underwent outpatient surgery (80.5%) with an average operative time of 180 minutes. The incidence of overall surgical complications was 5.1%. The following factors were independently associated with any surgical complications: morbid obesity (odds ratio [OR], 2.1; P < .001), active smoking (OR, 1.7; P < .001), history of dyspnea (OR, 2.0; P < .001), and resident participation (OR, 1.8; P = .01). The incidence of major surgical complications was 2.1%. Factors associated with major complications included active smoking (OR, 2.7; P < .001), dyspnea (OR, 2.6; P < .001), resident participation (OR, 2.1; P < .001), and inpatient surgery (OR, 1.8; P = .01). The authors concluded this study demonstrates overall incidence of complications in 1 in 20 patients and a 1 in 50 incidence of a major surgical complication. Noteworthy findings include the identification of morbid obesity as a significant predictor of overall morbidity and active smoking as a strong predictor of major surgical morbidity. These data can assist surgeons in preoperative counseling and enhance perioperative decision making.

Scientific Rationale - Update June 2009
It has been suggested that breast reduction surgery may be an alternative preventative option to prophylactic mastectomy for women at high risk of developing breast cancer.

For women who have a genetic mutation that predisposes them to breast and ovarian cancer, the currently accepted options include prophylactic surgery, intensified surveillance, and chemoprevention. There is no clear "best" choice among these alternatives and the choice usually depends on patient preference.

Prophylactic bilateral mastectomy has been demonstrated to reduce breast cancer incidence in women with a high inherited susceptibility to breast cancer. In both retrospective and prospective studies, prophylactic mastectomy decreases the incidence of breast cancer by 90 percent or more in women at high risk. A prospective study (Rebbeck et al 2004) of 105 healthy BRCA1/2 carriers who underwent prophylactic mastectomy demonstrated two cases of breast cancer after an average of 6.4 years of follow-up, compared with 184 cases of breast cancer among 378 mutation carriers matched for specific gene, center, and age who did not undergo the procedure. The two cases of breast cancer in women undergoing
prophylactic surgery occurred after subcutaneous rather than total mastectomy. Among mutation carriers undergoing bilateral mastectomy, the risk of subsequent breast cancer was reduced by 95 percent in women who had undergone prior or concurrent bilateral oophorectomy and by 90 percent in those with intact ovaries. Total (or simple) mastectomy is recommended for prophylaxis because subcutaneous mastectomy leaves behind more glandular tissue that remains at risk for future cancers.

Tarone et al (2004) reported that that several epidemiological follow-up studies have indicated that there may be a substantial reduction in breast cancer risk among women who have undergone breast reduction surgery. The authors note that although such observational studies cannot demonstrate definitively that reduction mammoplasty reduces the risk of breast cancer, the evidence from these studies is sufficiently strong to warrant the evaluation of breast reduction surgery as an option for primary prevention in clinical studies of women at increased risk of breast cancer. The authors suggest that the availability of a more acceptable surgical option for primary prevention of breast cancer could increase the number of women willing to choose risk reduction surgery and thus may result in an overall reduction in breast cancer mortality among high-risk women.

Brinton et al (2001) investigated whether the reduction in breast cancer risk was related directly to the amount of breast tissue removed. Medical record retrieval was attempted for 161 breast cancer patients in a Swedish cohort of 31,910 women who had had breast reduction surgery and for 483 women who had not developed breast cancer. Information on amount of breast tissue removed was abstracted along with other factors that influence breast cancer risk. Odds ratios of developing breast cancer were calculated based on amount of breast tissue removed. The amount of tissue removed was a significant predictor of risk, as subjects in the highest quartile of tissue removal had a significantly lower risk than those in the lowest quartile. Considering the total amount of tissue removed (both breasts), subjects with \( \geq 1600 \) versus \(< 800 \) grams removed had an odds ratio (OR) of 0.24. This relation persisted after adjustment for other breast cancer risk factors and was apparent within every subgroup examined.

Fryzek et al (2006) extended the above study yielding an average of nearly 16 years of follow-up. Standardized incidence ratios (SIRs) and 95% confidence intervals (CIs) were calculated comparing women who underwent breast reduction surgery with women in the general Swedish population. Breast cancer was observed in 443 women versus 624 expected for a statistically significant reduced SIR of 0.71 (95% CI=0.65-0.78). Analyses by age at surgery, time since surgery or calendar year of surgery revealed similar reductions in risk. The investigators concluded the study offers further evidence that women undergoing breast reduction surgery have reduced breast cancer risk. They recommend direct testing of this reduction in risk through clinical trials should be considered.

According to the American Society of Breast Surgeons, the National Comprehensive Cancer Network (NCCN), National Cancer Institute, American College of Obstetricians and Gynecologists and the American Cancer Society, risk reduction interventions for those at high risk for breast cancer include bilateral total mastectomy, bilateral salpingo-oophorectomy and/or chemoprevention. None of these societies make any recommendations for breast reduction surgery as a risk reducer for breast cancer in the average or high-risk individuals.
At this time, there is a lack of evidence from peer reviewed randomized control trials comparing the efficacy of reduction mammoplasty to other recommended treatments for the prevention of breast cancer in high risk individuals.

Scientific Rationale - Update February 2007

There are no current criteria specifically developed for adolescent candidates for reduction surgery, although many of these young women may have severe physical symptoms. Therefore, the demographics and outcomes of these patients are of particular interest in determining the risks and benefits particular to this surgery for younger patients. Lee et al (2003) pooled 73 patients who had undergone bilateral reduction mammoplasty between 1981 and 2000. Patient ages ranged between 12.5 and 18.9 years, with a mean age of 16.1 years. Their two-pronged investigation involved examination of demographics of the adolescent population and short- and long-term outcomes and satisfaction. Demographic survey included age, weight, height, BMI, breast size, and amount of tissue removed. Indications for surgery and postoperative complications were surveyed in office records and via questionnaire. Seventeen patients (23%) were successfully contacted and returned a detailed questionnaire evaluating indications for surgery, preoperative and postoperative complications, and overall satisfaction. Eighty-two percent of patients reported resolution of their physical symptoms, including back, shoulder, and neck pain. Self-esteem, however, was cited most commonly as a reason to recommend this procedure to other adolescent women. Nearly 65% of respondents would repeat their adolescent surgical experience, and 82.4% would recommend this procedure to a teenaged friend in a similar situation. The authors' data suggest that adolescent patients benefit significantly from reduction mammoplasty and that long-term satisfaction remains high, despite the age of the patients at surgery.

Collins et al (2002) conducted the only study evaluating the effectiveness of breast reduction and conservative treatments in alleviating the symptoms of macromastia. The study had a prospective design with a surgical intervention group and two control groups: a hypertrophy control group with bra cup sizes D or larger and a normal control group with bra cup sizes less than D. The effectiveness of nonsurgical interventions in relieving the symptoms of macromastia was also evaluated, both in the operative subjects and in the control groups. Surgical candidates and controls completed a self-administered baseline survey that consisted of the following validated and standardized instruments commonly used to evaluate outcomes: SF-36, EuroQol, Multidimensional Body-Self Relations Questionnaire (MBSRQ), and the McGill Pain Questionnaire (MPQ). A specially designed and validated instrument, the Breast-Related Symptoms (BRS), was also used. There were also questions about prior nonsurgical treatments, comorbid conditions, bra size, and a physical assessment. Additional information obtained on the operative subjects included surgical procedure data, resection weight, and complications. Approximately 6 to 9 months postoperatively, surgical subjects completed the same questionnaire as described above, and a final physical assessment was performed. The cohort included 179 operative subjects with matched preoperative and postoperative data sets, 96 normal controls and 88 hypertrophy controls. Fifty percent of the operative subjects reported breast-related pain all or most of the time in the upper back, shoulders, and neck preoperatively compared with less than 10 percent postoperatively. Operative subjects and hypertrophy controls tried a number of conservative treatments, including weight loss, but none provided adequate permanent relief. Compared with population norms, the preoperative subjects had significantly lower scores in all eight health domains of the SF-36, and in the mental and physical component summary scores. After surgery, the operative subjects had higher means (better health) than national norms in seven of the eight domains and...
improved significantly from presurgical means in all eight domains. Before surgery, the operative subjects reported high levels of pain with a Pain Rating Index (PRI) score from the MPQ of 26.6. After surgery, pain was significantly lower with a mean PRI score of 11.7, similar to that of our controls (mean PRI score, 11.2). Regression analysis was used to control for covariate effects on the main study outcomes. Among the operative subjects, benefits from breast reduction were not associated with body weight, bra cup size, or weight of resection, with essentially all patients benefiting from surgery. Breast hypertrophy has a significant impact on women's health status and quality of life as measured by validated and widely used self-report instruments including the SF-36, MPQ, and EuroQol. Pain is a significant symptom in this disease, and both pain and overall health status are markedly improved by breast reduction. In this population, conservative measures such as weight loss, physical therapy, special brassieres, and medications did not provide effective permanent relief of symptoms.

Behmand et al (2000) conducted a non-randomized prospective survey in 69 consecutive patients who underwent bilateral reduction mammoplasty with their preoperative state and also an age matched control population as regards improvement of their general health, both physical and emotional. Patients were surveyed pre-operatively and at nine months post-operatively. The group of patients considered for this study reported poorer mental health and substandard social functioning preoperatively in comparison with age matched control group. It was found that macromastia contributes to inferior physical functioning, increased reports of bodily pain, anxiety, depression and difficulty with interpersonal interactions. Patients who underwent bilateral reduction mammoplasty reported restoration of physical and psychological health, equal to or surpassing that of control groups. The findings provide a compelling argument for the therapeutic nature of breast reduction surgery, as well as support the efficacy of the procedure in alleviating multiple physical and psychological symptoms resulting from macromastia.

Greenbaum et al (2003) reported their case series of 102 women investigating the suitability of bra fit in women referred for reduction mammoplasty. They suspected that women seeking reduction mammoplasty often wear ill-fitting bras that are likely to exacerbate some of their symptoms. It is suggested that correctly fitting bra might alleviate symptoms and possibly even remove the wish for surgery. The authors found that the ill-fitting bras worn contributed to back and neck pain, shoulder grooves and intertrigo and concluded that conservative measures such as correct bra fitting may result in fewer women resorting to surgery.

Chadbourne (2001) carried out a systematic review and meta-analysis of published studies on clinical outcomes in reduction mammoplasty, i.e., quality of life, signs and symptoms pre- and post-operatively. Most of the studies in the review were observational and retrospective in design and represented the best available evidence on the subject of reduction mammoplasty and physical and psychosocial outcomes. Meta-analysis revealed that improvement occurred in all signs and symptoms examined. Despite these results, the debate has continued as to whether reduction mammoplasty is cosmetic or medically necessary.

Numerous reports have attested to the fact that there is abundant evidence to suggest that those who undergo reduction mammoplasty for the right reasons derive significant improvements in physical health and quality of life. Shakespeare (1997) found that there is evidence to suggest that patients with a BMI >30 are likely to benefit as much as others following breast reduction. Brown et al (2000) surveyed
74 patients postoperatively and 92% of patients would go through the operation again feeling it was worthwhile because there was a marked reduction in pre-operative signs and symptoms. In a survey conducted by Mizgala et al (2000), 73 patients reported improvement in posture 84% and activity levels 77%. The effect on back pain was statistically significant with 41% reporting severe back pain pre-op dropping to zero postoperatively. Percentage reporting no back pain pre-op rose from 9% to 59%. Collins et al (2002) presented their prospective controlled, multicenter study on 179 operative patients and 194 control subjects (88 hypertrophy controls and 96 normal controls) concluded that pain and overall health were markedly improved by breast reduction, essentially restoring functional status to that of age matched norms. The surgical cohort gained substantial symptomatic relief. This study also demonstrated that overweight women, who undergo breast reduction, gain as much relief of physical symptoms and pain as women of normal weight. Weight loss is not effective in relieving symptoms of breast hypertrophy. The prospective case study of Jerome et al (2002) concluded that the indications for surgery include disability, pain, decreased back muscle strength, poor posture and disproportionate breast size for the patient’s BMI.

In conclusion, the signs and symptoms of breast hypertrophy are definable in a consistent manner. There is no question that reduction mammoplasty can be considered a functional operation and is the only treatment which improves quality of life of symptomatic women on a long-term basis. It has been shown time after time that reducing breast size and weight can effect a statistically significant improvement in the objective measures of pain, disability, muscle weakness, poor posture and general overall health.

Scientific Rationale - Update April 2006
In their Position Paper on March 9, 2002, the American Society of Plastic Surgeons (ASPS) recommended insurance coverage criteria for third-party payers for reduction mammoplasty as follows:

“The justification for reduction mammoplasty should be based on the probability of relieving the clinical signs and symptoms of macromastia. Because it is difficult to determine the size at which breast enlargement becomes pathologic in any individual, it is the position of ASPS that the definition of macromastia should focus on the degree of symptomology, not the degree of breast hypertrophy present (cup size or amount of tissue removed).”

“The removal of a specified amount of breast tissue has not been correlated with a reduction or elimination of symptoms. Virtually all women who underwent breast reduction for symptomatic hypertrophy experienced an improvement in their symptoms and health related quality of life, regardless of the weight of breast tissue removed. Therefore, coverage should be based on documentation of symptoms of macromastia regardless of body weight or weight of breast tissue removed.”

Scientific Rationale - Update April 2005
Sommer et al (2002) sought to develop a simple, clinically useful method for predicting weight of breast tissue to be removed, using routine, easily obtained predictors (i.e., height, weight, age, measurements from sternal notch to nipple, and measurements from sternal notch to inframammary crease). Data were available
from a retrospective review of 263 women undergoing reduction mammoplasty. Analyses were performed to predict resected weights obtained both in the operating room and by a pathologist for left and right breasts separately. Regression analyses showed that the sternal notch-to-nipple measurement accounted for nearly all of the explained variance in the resected weights, with correlations around 0.80 between sternal notch to nipple and resected weight. For sternal notch-to-nipple measurements ≥ 28.5 cm, predicted resected weights were approximately 600 g or more, and in general, 80 percent or more patients had specimen weights > 500 grams. From 25.5 to 28 cm, the predicted weights ranged from about 400 to 600 g and the prediction rate of weights > 500 g was 50 percent. The senior author predicted the resected breast weight to be > 500 g 94 percent of the time. The equation alone did not produce an accurate prediction in the critical range, 400 to 600 g. The experienced surgeon more accurately predicted resected weights with use of practiced spatial relationship skills.

Cruz-Cochin et al (2002) determined that the mean fat percentage in the central breast area was 61%, 74% in the lateral breast area, and 73% in the preaxillary area. Upon microscopic examination, the pathologist reported that fat accounted for 64 percent of the central breast area, 92 percent of the lateral breast area, and 94 percent of the preaxillary area. On average, the central breast area in macromastia patients had only seven percent gland and 29 percent connective tissue. The study concurred that the enlarged breast of macromastia consists primarily of fat and that the glandular element is rather small. Weight loss may or may not help with breast size, but some physicians will want individuals to reduce their weight before considering breast reduction mammoplasty.

Kompatscher et al (2005) retrospectively studied 136 women with both cosmetic and reconstructive indications to judge the minimum resection weight standards currently in place and see whether they were appropriate to use, or to provide an objective and measurable guideline for a scaled amount of breast reduction beyond the 500 g-resection-rule. From all examined parameters, the BMI had the highest correlation to the resected mean breast tissue and that an arbitrary 500 g breast resection-rule clearly put women at a disadvantage. Also not completely solving this problem are the already available, more objective guidelines for graded minimum resection weight recommendations, which have relied on the body weight or the body surface area, parameters that both had a much lower correlation to the resected breast tissue in the patient group than the BMI. Therefore, they suggested using the BMI as the basis for a graded, more-level weight resection standard for reconstructive breast reductions. This algorithm is related solely to objectifying data and thus avoids biases from empirically derived data or hardly quantifiable breast (or obesity)-related pain syndromes, and respects all the different body builds of women.

Collins et al (2002) evaluated the effectiveness of breast reduction in alleviating the symptoms of macromastia by comparing baseline and postoperative health status using a series of well-validated self-report instruments. They concluded that pain is a significant symptom in this disease, and both pain and overall health status are markedly improved by breast reduction. In this population, conservative measures such as weight loss, physical therapy, special brassieres, and medications did not provide effective permanent relief of symptoms.

**Scientific Rationale - Initial**

Macromastia, also known as breast hypertrophy or enlarged breasts, is the development of abnormally large breasts in females. Macromastia is distinguished
from large, normal breasts by the presence of persistent, painful symptoms, physical signs, and functional impairment. Reduction mammoplasty is the surgical excision of a substantial portion of the breast including the skin and the underlying glandular tissue, until a clinically normal size is obtained. Because breasts are paired organs and macromastia usually affects both sides, bilateral surgery is performed. When there is significant one-sided hypertrophy, a unilateral breast reduction is performed. Reduction mammoplasty is usually prompted by physical necessity due to the signs and symptoms of macromastia, and is, therefore, reconstructive in nature.

Women who request breast reduction should be within their ideal weight range or slightly above it. Because this operation is an elective procedure, obese women should lose weight not only to facilitate the surgery but also to avoid medical complications secondary to the obesity. Because a woman's breast is related to her overall size, she may feel she is still too large or even too small after the surgery. Any significant weight loss after the reduction can result in breasts that are too small or ptotic. The woman who is the ideal candidate for breast reduction surgery is comfortable with her size and has been at her present weight for many years. Macromastia can cause significant clinical manifestations when the weight of excessive breast adversely affects the supporting musculature of the shoulder, neck, and trunk. Women with very large, pendulous breasts may experience a variety of medical problems, skin irritation, skeletal deformities, ulnar nerve parasthesias and breathing problems. Bra straps may leave indentations (grooves) in their shoulders. And unusually large breasts can make a woman or a teenage girl feel extremely self-conscious. Presence of low back pain as a symptom of macromastia is not supported in the published literature.

Weight guidelines for breast tissue resection or reduction in bra-cup size are not valid since they are poorly correlated with relief of the symptoms of macromastia. There are wide variations in the range of normal individual height, body weight and associated breast sizes; the amount of breast tissue that must be removed to relieve symptoms therefore varies with the height and weight of each patient (e.g., a small-statured person will need proportionally less breast tissue removed to alleviate signs and symptoms of macromastia than a larger person.

Reduction mammoplasty removes fat, glandular tissue and skin from the breasts, making them smaller, lighter and firmer. It can also reduce the size of the areola. Unfortunately, limited evidence is found in the published literature comparing medical to surgical treatment, however, empirical evidence supports the use of surgical intervention when medical modalities have failed. Evidence of surgical effectiveness as compared to medical intervention as yet needs to be documented in tightly controlled, randomized clinical trials assessing effects on pain, disability, and function. In the case of reduction mammoplasty for relief of back, neck and shoulder pain, when all possible causes for persistent pain have been ruled out (i.e. intradiscal pathology, arthritis etc.) removal of excessive breast tissue (i.e., greater than 500 gms) has been shown to provide relief of pain, improved daily functioning and reduction in disability. Well-controlled clinical studies have not been performed to assess the effectiveness of surgical removal of modest amounts of breast tissue (less than 500 gms) in reducing neck, shoulder, and back pain and related disability in women. As well, reduction mammoplasty needs to be compared with other established methods of relieving back, neck and shoulder pain. There is insufficient evidence to support the use of reduction mammoplasty as a method of relieving chronic back, neck, or shoulder pain, without giving consideration to the amount of breast tissue to be removed.
Review History

June 2004  Initial Approval by Medical Advisory Council
April 2005  Update
October 2005  Revision – placed both medication and PT failure under upper back, neck, and shoulder pain
April 2006  Revision - Removed amount of tissue to be removed as a criterion
February 2007  Revision - changed criterion for age, removed requirement of physical therapy
March 2007  Coding Updates
August 2008  Updated. Reformatted notes within policy statement. No other changes. Reviewed codes. CA reconstructive surgery law added to Disclaimer.
June 2009  Added reduction mammoplasty for the primary purpose of reducing breast cancer risk to the investigational section of the policy.
April 2011  Update. Added Medicare Table with link to LCDs. No revisions.
April 2012  Update. Removed ‘For women who intend to become pregnant and breast-feed’ from not medically necessary list.
April 2014  Update – no revisions
April 2015  Update – no revisions

This policy is based on the following evidence-based guidelines:


References – Update April 2016


References – Update April 2015

References – Update April 2014

References – Update April 2013

References – Update April 2012

References – Update April 2011

References – Update June 2009

References – Update September 2008

References – Update February 2007

References – Update April 2006
References - Update – March 28, 2005

References - Initial
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Important Notice

General Purpose.
Health Net’s National Medical Policies (the "Policies") are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The member’s contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps. The policy provides for clearly written, reasonable and current criteria that have been approved by Health Net’s National Medical Advisory Council (MAC). The clinical criteria and medical policies provide guidelines for determining the medical necessity criteria for specific procedures, equipment, and services. In order to be eligible, all services must be medically necessary and otherwise defined in the member's benefits contract as described this "Important Notice" disclaimer. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member’s benefits, nor is it intended to dictate to providers how to practice medicine.

Policy Effective Date and Defined Terms.
The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. All policies are subject to applicable legal and regulatory mandates and requirements for prior notification. If there is a discrepancy between the policy effective date and legal mandates and regulatory requirements, the requirements of law and regulation shall govern. * In some states, prior notice or posting on the website is required before a policy is deemed effective. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

Policy Amendment without Notice.
Health Net reserves the right to amend the Policies without notice to providers or Members. In some states, prior notice or website posting is required before an amendment is deemed effective.

No Medical Advice.
The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

No Authorization or Guarantee of Coverage.
The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

Policy Limitation: Member’s Contract Controls Coverage Determinations.
Statutory Notice to Members: The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member’s contract, and requirements of applicable laws and regulations. The contract language contains specific terms and...
conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Member’s contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member’s contract shall govern. The Policies do not replace or amend the Member’s contract.

Policy Limitation: Legal and Regulatory Mandates and Requirements
The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

Reconstructive Surgery
CA Health and Safety Code 1367.63 requires health care service plans to cover reconstructive surgery. “Reconstructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function or
(2) To create a normal appearance, to the extent possible.

Reconstructive surgery does not mean “cosmetic surgery,” which is surgery performed to alter or reshape normal structures of the body in order to improve appearance.

Requests for reconstructive surgery may be denied, if the proposed procedure offers only a minimal improvement in the appearance of the enrollee, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery.

Reconstructive Surgery after Mastectomy
California Health and Safety Code 1367.6 requires treatment for breast cancer to cover prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits. “Mastectomy” means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Policy Limitations: Medicare and Medicaid
Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.