Definitons:

**Breast Reduction Mammaplasty**
The surgical alteration that reduces the total breast size relative to individual Body Surface Area (BSA), on a person with no medical history of mastectomy.

**Mastopexy**
Performed to assist sagging breast(s)

**Gynecomastia**
A benign enlargement of the male breast resulting from a proliferation of the glandular component of the breast.

Policy:
To ensure that corporate authorization processes are consistent in the adjudication of Reduction Mammaplasty, Mastopexy and Gynecomastia surgery.

Procedure:
1. The procedure must be prior authorized by Meridian Health Plan.
2. A reduction Mammaplasty will be covered for Meridian Health Plan members meeting all of the following criteria:
   A. The medical record must show documentation of at least 2 of the following criteria, present for at least 6 months and which have not responded adequately to appropriate conservative, non-surgical interventions (including but not limited to):

Special Instructions Alert: N/A
i. Back, neck or shoulder pain of long standing duration (6 months) that has been evaluated by a physiatrist, neurologist or spine surgeon and determined not to be related to other diagnosis such as scoliosis, arthritis or of a mechanical nature. And that has not responded to at least three consecutive months of conservative measures including, but not limited to, all of the following:
   a) Appropriate support bra (e.g. sports type with wide straps)
   b) Exercises
   c) Heat/cold treatments
   d) Non-steroidal anti-inflammatory agents (NSAID’s) and/or
   e) Muscle relaxants

ii. Ulceration of the skin of the shoulder or significant and longstanding shoulder grooving not responding to conservative treatment over a 12-month period.

iii. Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold between the pendulous breasts and the chest wall, not responsive to at least six months of dermatologic treatments (e.g. antibiotics and/or antifungal therapy) directed by a dermatologist and conservative measures (e.g. good skin hygiene). By themselves, these dermatologic problems are not considered medically necessary indications for reduction mammoplasty.

B. The amount of breast tissue removed must exceed the 22% minimum, in grams per breast (averaged if significant asymmetry exists), according to the Schnur Sliding Scale (below).

C. If determined by Medical Director review, a second opinion and/or evaluation may be required by Meridian Health Plan to help further define members who may be appropriate for the procedure to assure that:
   1. There is a reasonable likelihood that the member's symptoms are primarily due to macromastia; and
   2. Reduction mammoplasty is likely to result in improvement of the chronic pain; and
   3. Pain symptoms persist as documented by the physician despite at least a 6-month trial of therapeutic measures.

D. The medical record must also include documentation of all of the following:
   i. Age 18 years of age or older.
   ii. Clear pictures defining shoulder grooving and/or inframammary skin changes.
   iii. Women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty.
   iv. Macromastia on physical exam.

3. All other breast reduction procedures/surgeries are considered investigational and are not a covered benefit.
4. There is no clinical evidence to support performing breast reduction surgery in members 17 years of age or younger.
5. A Mastopexy is considered a cosmetic procedure to assist sagging breasts and is not covered.
6. Gynecomastia. There is no functional impairment associated with this disorder. This procedure is seldom indicated as something other than cosmetic in nature and surgical removal is therefore, rarely indicated except in the case of suspected cancer or other health/life threatening conditions.
7. Surgery is not being performed for breast asymmetry (excluding asymmetry related to malignancy).

The Schnur Sliding Scale Table
The average grams of breast tissue removed or anticipated to be removed must be greater than the threshold value for a given BSA in order for the surgery to be considered Medically Necessary AND WHEN ALL OF THE OTHER INDICATIONS AND CRITERIA NOTED ABOVE ARE MET.
1. If the BSA as compared to the average grams of breast tissue removed or anticipated to be removed is less than the threshold value for a given BSA, then the surgery is NOT Medically Necessary.

Body surface area and the threshold for the average weight of breast tissue needing to be removed (>22’ile)

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Special Instructions: N/A

CPT/HCPCS Codes:

11920, 11921, 11922, 11970, 11971, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19380, 19396, L8020, L8039, L8600, S2067, S2068, 19300, 18304

Approved by: ____________________________________

Corporate Chief Operating Officer

Date: 01/13/2016

Reviewed and approved by Medical Policy and Procedures Committee: Date: 11/30/2015

Reviewed and approved by Medical Policy Operations Committee: Date: 12/04/2015

Reviewed and approved by Physician Advisory Committee: Date: 12/18/2015

Reviewed and approved by Healthcare Compliance Subcommittee: Date: 01/13/2016

References:


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