



FEP Medical Policy Manual

FEP 7.01.21 Reduction Mammoplasty

Effective Policy Date: July 1, 2020

Original Policy Date: March 2012

Related Policies:

7.01.13 surgical Treatment of Bilateral Gynecomastia

Reduction Mammoplasty

Description

Macromastia, or gigantomastia, is a condition that describes breast hyperplasia or hypertrophy. Macromastia may result in clinical symptoms such as shoulder, neck, or back pain, or recurrent intertrigo in the mammary folds. In addition, macromastia may be associated with psychosocial or emotional disturbances related to the large breast size. Reduction mammoplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or to relieve the associated clinical symptoms.

OBJECTIVE

The objective of this evidence review is to evaluate the clinical situations where the evidence demonstrates that reduction mammoplasty improved the net health outcome.

POLICY STATEMENT

Reduction mammoplasty may be considered **medically necessary** for the treatment of macromastia when well-documented clinical symptoms are present, including but not limited to:

- Documentation of a minimum 6-week history of shoulder, neck, or back pain related to macromastia not responsive to conservative therapy, such as an appropriate support bra, exercises, heat/cold treatment, and appropriate nonsteroidal anti-inflammatory agents or muscle relaxants.

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- Recurrent or chronic intertrigo between the pendulous breast and the chest wall.

Reduction mammoplasty is considered **investigational** for all other indications not meeting the above criteria.

POLICY GUIDELINES

The presence of shoulder, neck, or back pain is the most common stated *medical* rationale for reduction mammoplasty. However, because these symptoms and others may be subjective, various patient selection criteria designed to be more objective may be used to support the criteria. They include:

- Use of photographs, providing a visual documentation of breast size or documenting the presence of shoulder grooving, an indication that the breast weight results in grooving of the bra straps on the shoulder.
- Requirement of a specified amount of breast tissue to be resected, commonly 500 to 600 grams per breast.
- Use of the Schnur Sliding Scale, which suggests a minimum amount of breast tissue to be removed for the procedure to be considered medically necessary, based on the patient's body surface area. Some Plans may use the Schnur Sliding Scale only for weight of resected tissue that falls below 500 to 600 grams.
- Requirement that the patient must be within 20% of ideal body weight to eliminate the possibility that obesity is contributing to the symptoms of neck or back pain.

BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

Medical policies regarding reduction mammoplasty have focused on the distinction between a cosmetic procedure, performed primarily to improve the appearance of the breast, and a medically necessary procedure, performed primarily to relieve documented clinical symptoms. It should be noted that the emotional and psychosocial distress associated with body appearance does not constitute a *medical* rationale for reduction mammoplasty, and thus these indications would be considered cosmetic.

Determinations of whether a proposed therapy would be considered reconstructive or cosmetic should always be interpreted in the context of the specific benefits language.

FDA REGULATORY STATUS

Reduction mammoplasty is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

RATIONALE

Summary of Evidence

For individuals who have symptomatic macromastia who receive reduction mammoplasty, the evidence includes systematic reviews, randomized controlled trials, cohort studies, and case series. Relevant outcomes are symptoms and functional outcomes. Studies have indicated that reduction mammoplasty is effective at decreasing breast-related symptoms such as pain and discomfort. There is also evidence that functional limitations related to breast hypertrophy are improved after reduction mammoplasty. These outcomes are achieved with acceptable complication rates. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

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SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

American Society of Plastic Surgeons

In 2011, The American Society of Plastic Surgeons issued practice guidelines and a companion document on criteria for third-party payers for reduction mammoplasty.^{20,21} The Society found that level I evidence has shown reduction mammoplasty is effective in treating symptomatic breast hypertrophy, which "is defined as a syndrome of persistent neck and shoulder pain, painful shoulder grooving from brassiere straps, chronic intertriginous rash of the inframammary fold, and frequent episodes of headache, backache, and neuropathies caused by heavy breasts caused by an increase in the volume and weight of breast tissue beyond normal proportions." The Society also indicated the volume or weight of breast tissue resection should not be criteria for reduction mammoplasty. If two or more symptoms are present all or most of the time, reduction mammoplasty is appropriate. This practice guideline has been officially archived and an update is scheduled for 2019.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

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POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
March 2012	New policy	
March 2013	Replace policy	Policy updated with literature review; references 14, 19-20 and 23 added; Policy statements unchanged
March 2014	Replace policy	Policy updated with literature review; no references added; Policy statements unchanged
March 2015	Replace policy	Policy updated with literature review; references 20-21 added; reference 13 deleted. Policy statement added indicating reduction mammoplasty is considered not medically necessary for all other indications not meeting medically necessary criteria.
March 2017	Replace policy	Policy updated with literature review; references 14 and 22 added; Policy statements unchanged
June 2018	Replace policy	Policy updated with literature review through December 11, 2017; no references added; a citation removed as out-of-scope and references. Policy statements unchanged except not medically necessary statement corrected to "investigational".

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Date	Action	Description
June 2019	Replace policy	Policy updated with literature review through December 6, 2018; no references added; reference 20 updated. Policy statements unchanged.
February 2020	Replace policy	Policy updated with literature review through November 27, 2019; no references added. Policy statements unchanged.

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