

## Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy

### MPM 2.5

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**Disclaimer**

Refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

**Description**

Reduction mammoplasty is a surgical procedure performed to reduce the volume and weight of the female breasts. It is one of the most common plastic surgery procedures performed in the United States and may be considered reconstructive or cosmetic. A reduction mammoplasty is considered reconstructive surgery when there is a physiological impairment caused by symptomatic breast hypertrophy; the intent of breast reduction surgery is to resolve the symptoms and alleviate the physiological impairment.

Cosmetic surgery performed to shape normal structures of the body in order to improve the patient's appearance and self-esteem is **not** a covered benefit.

Other related medical policies:

- MPM 7.0, Gynecomastia (Surgical Treatment)
- MPM 2.11 Breast Reconstruction Following Mastectomy

**Coverage Determination**

**Reduction mammoplasty requires Benefit Certification.** Log on to Pres Online to submit a request: <https://ds.phs.org/preslogin/index.jsp>.

**See page 2 for  
Medicare Coverage  
Determination**

**All** requests must be accompanied with the following documentation:

- An estimation of the amount of breast tissue to be removed
- Symptoms necessitating reduction mammoplasty
- Height, weight, BMI and bra size

Breast reduction mammoplasty is covered when the patient's symptoms of pain, disability or infection are primarily caused by significant breast hypertrophy. Relevant conditions that could explain symptoms should have been fully evaluated and treated. The following criteria must be met:

I. Bilateral Breast Reduction:

- The amount of breast tissue to be removed will vary with the height and weight of each patient, but should be an adequate amount to relieve the symptoms of significant breast hypertrophy. **It is anticipated that at least 350 grams of excess tissue be removed from each breast.**

All requests for patients with less than 350 grams of excess tissue to be removed must be sent for medical director review.

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- At least **one** of the following must be present:
  - A history of upper back, neck and/or shoulder region pain adversely affecting function that can reasonably be attributed to breast size; **or**
  - Deep grooves in shoulder with discomfort and redness due to pressure from bra straps, despite the use of a support bra with weight distributing straps; **or**
  - Intertriginous rash not responsive to topical antifungal or antibacterial therapy and other conservative applications; **or**
  - Arm paresthesia due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area.
  
- Negative mammogram within the past year for patients over 35 years of age.

#### II. Unilateral Breast Reduction:

- **One** of the following must be present:
  - Significant one-sided hypertrophy, which meets the above criteria for bilateral breast reduction; **or**
  - Asymmetry of contralateral breast after breast cancer surgery

#### Coverage Determination for Medicare members

For Senior Plan members: PHP follows the Medicare guidelines in TrailBlazer Health Enterprises Local Coverage Determination L26720. Requirements for coverage of reduction mammoplasty for Medicare members are detailed in the TrailBlazer's LCD and can be accessed on the Internet at the following link:

[http://www.cms.gov/mcd/viewlcd.asp?lcd\\_id=26720&lcd\\_version=12&show=all](http://www.cms.gov/mcd/viewlcd.asp?lcd_id=26720&lcd_version=12&show=all)

#### Exclusions

Reduction mammoplasty for cosmetic purposes is not a covered benefit.

#### Medical Terms

Reduction mammoplasty is the surgical removal of excess breast tissue to reduce the weight and size of the breast. Breast reduction includes removal of excess tissue and the lifting of the breasts, as described in CPT 19318. Neither the patient nor PHP should be billed for a separate mastopexy (CPT 19316). Liposuction involving the lateral chest wall or breast itself, which may be combined with reduction mammoplasty, is not covered by PHP.

Breast hypertrophy is an increase in the volume and weight of breast tissue relative to the body habitus. Breast hypertrophy is considered abnormal when it causes functional impairment and interferes with the health of the member.

**Breast Reduction Mammoplasty for Symptomatic Breast Hypertrophy**  
**MPM 2.5****Coding**

The coding listed in this Medical Policy is for reference only.  
Covered and non-covered codes are included in this list.

<b>CPT Codes</b>	<b>Description</b>
19318	Reduction mammoplasty

<b>ICD-9© Diagnosis Codes</b>	<b>Description</b>
611.0	Inflammatory disease of breast
611.1	Hypertrophy of breast
611.3	Fat necrosis of breast
611.71	Mastodynia
611.8	Other specified disorders of breast
692.9	Unspecified cause dermatitis
695.89	Other specified erythematous condition (intertrigo)
709.9	Unspecified disorder of skin and subcutaneous tissue (permanent shoulder grooving from bra straps)
719.41	Pain in joint, shoulder region
723.1	Cervicalgia
724.1	Pain in thoracic region
724.5	Backache, unspecified
781.92	Abnormal posture
782.0	Disturbance of skin sensation

**Reviewed**

1. Luis Cuadros, MD, Plastic Surgery, 2001, April 2007, June 2008, September 2009
2. Chester Sakura, MD, Plastic Surgery, June 2002, October 2003, November 2004
3. Bret R. Baack, MD, Associate Professor, Division of Plastic Surgery, University of New Mexico, October 2003
4. John Finley, MD, Presbyterian Medical Group, January 2006, May 2008, September 2009

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage.

[MPMPPC081010]

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- Reference**
1. Centers for Medicare and Medicaid. TrailBlazer Health Enterprises. Local Coverage Determination L26720. Mammoplasty, Reduction. Effective date 03-01-08.
  2. Hayes Directory. Copyright © 2008 Winifred S. Hayes, Inc. Reduction Mammoplasty. December 18, 2008. Update search 12-30-09.
  3. Milliman Care Guidelines, Ambulatory Care, 14<sup>th</sup> edition, "Reduction Mammoplasty," 02-09-10.
  4. Schnur, Paul L, et al., "Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?" *Annals of Plastic Surgery*. Sept 1991; 27 (3): 232-7.
  5. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage for Third-Party Payers, "Reduction Mammoplasty," 2002.
  6. Kerrigan, Carolyn L. MD, et al., "Reduction Mammoplasty: Defining Medical Necessity." *Medical Decision Making*, May-June 2002.
  7. Kompatscher, Peter MD, et al., "A body mass index related scale for reconstructive breast reduction." *European Journal of Plastic Surgery* (2003) 26:202-206.
  8. Nguyen, JT, et al., "Reduction Mammoplasty: A Review of Managed Care Medical Policy Coverage Criteria." Copyright ©2008 by the American Society of Plastic Surgeons.

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12-01-10 Revision, removed "Photographic documentation confirming severe breast hypertrophy"

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This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and medical directors may use them in reviewing the case. Please note that all Presbyterian Medical Policies are available on the Internet at:

<http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm>

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