POLICY AND PROCEDURE MANUAL

Policy Title: Reduction Mammoplasty, Mastopexy, Gynecomastia Surgery	**Policy Number: F.01**
Primary Department: Medical Management **Affiliated Department(s): N/A**	**NCQA Standard: N/A** **URAC Standard: N/A**
Last Revision Date: 06/2019 **Revision Dates: 03/2012; 07/2012; 08/2012; 02/2013; 01/2014; 01/2015; 11/2015; 12/2016; 10/2017; 02/2018; 10/2018; 06/2019** **Effective Date: 08/29/2008**	**Next Review Date: 07/1/2020** **Review Dates: 08/29/2008; 11/21/2008; 04/24/2009; 03/26/2010; 03/25/2011; 03/23/2012; 09/26/2012; 03/22/2013; 04/30/2014; 03/27/2015; 12/18/2015; 12/20/2016; 12/13/2017; 03/28/2018; 12/19/2018; 6/26/2019**
Applicable Lines of Business:☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☒MeridianChoice	
Applicable States: ☐All ☒MI ☒IL ☐OH ☐_______ ☐________	
Applicable Programs: ☒All ☐Other ________________________	
Policy is to be published: Internally Only ☐ Internally & Externally ☒	

Definitions:

Breast Reduction Mammoplasty	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.
Body Surface Area Formula	The calculation is from the formula of DuBois and DuBois: BSA = (W 0.425 x H 0.725) x 0.007184
Morbid Obesity	BMI 40
Macromastia	Excessive growth of the mammary glands

Policy:

To ensure that corporate authorization processes are consistent in the adjudication of Reduction Mammaplasty, Mastopexy and Gynecomastia surgery. Reconstructive surgery is to correct or improve a functional condition or physiologic impairment. Breast reduction surgery is considered cosmetic unless breast hypertrophy is causing significant neck or back pain, ulceration, paresthesia, or infra-mammary skin conditions (see criteria below).

Procedure:

Criteria for Coverage:

The procedure must be prior authorized by Meridian Health Plan.

All requests utilizing the F.01 policy must be sent to Mandatory MD review.

A **Reduction Mammoplasty** will be covered for Meridian Health Plan members meeting all of the following criteria (**must meet criteria numbered 1, 2. & 3**):

1. The medical record must show documentation of **1 of the following criteria (from criterion a-d)**, present for at least 6 months:
   a. Back, neck or shoulder pain of long standing duration (6 months) that has been evaluated by a physiatrist, neurologist, orthopedic surgeon, 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 all of the following:
      i. Appropriate support bra (e.g. sports type with wide straps)
      ii. Physician supervised, exercises and/or Physical Therapy
      iii. Conservative analgesia - Non-steroidal anti-inflammatory agents (NSAID's) and/or
      iv. Muscle relaxants
   b. Ulceration of the skin of the shoulder and significant and longstanding shoulder grooving not responding to conservative treatment over a 12-month period.
   c. 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:
      i. Conservative measures (e.g. good skin hygiene) documented AND
      ii. Dermatologist evaluation and treatment (e.g. antibiotics and/or antifungal therapy.
   d. Upper extremity paresthesia due to brachial plexus compression syndrome. An example is ulnar nerve compression with finger paresthesia. Must be of long standing duration (6 months) and evaluated by a neurologist and determined not to be related to another diagnosis.
2. The medical record must also include documentation of all of the following:
   a. Age 18 years of age or older.
   b. Clear pictures defining shoulder grooving and ulceration and /or inframammary skin changes.
   c. 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.
   d. Macromastia on physical exam.
3. 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).

4. A **Mastopexy** is considered a cosmetic procedure to assist sagging breasts and is not medically necessary and therefore not a covered benefit.

5. A **Gynecomastia** 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. There is no functional impairment associated with this disorder. As a cosmetic procedure this service is not medically necessary and therefore not a covered benefit.

Absolute Contraindications:

1. Age less than 18 High-risk surgical patients with substantial medical comorbidities (cardiopulmonary disease, morbid obesity, defined as BMI over 40 for purposes of this policy).
2. Surgery is being performed for breast asymmetry (excluding asymmetry related to malignancy).
3. Reduction mammoplasty to treat fibrocystic disease of the breasts

4. All other breast reduction procedures/surgeries (eg breast liposuction) are considered investigational and are not medically necessary
5. Cigarette smoking is associated with multiple complications (e.g., slowed wound healing, increased risk for infection). Smoking is, therefore, considered a contraindication. Patients should abstain from smoking for at least 3 months prior to surgery.

Appendix A

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)

Body Surface Area	Threshold Value for the average grams of tissue per breast to be removed	Body Surface Area	Threshold Value for the average grams of tissue per breast to be removed
1.35	199	2.00	628
1.40	218	2.05	687
1.45	238	2.10	750
1.50	260	2.15	819
1.55	284	2.20	895
1.60	310	2.25	978
1.65	338	2.30	1068
1.70	370	2.35	1167
1.75	404	2.40	1275
1.80	441	2.45	1393
1.85	482	2.50	1522
1.90	527	2.55	1662
1.95	575		

Line of Business Applicability:

This policy will apply to Michigan Medicaid, Illinois Medicaid, and Individual Plans.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the invidual insurance policy will govern.

State specific special instructions:

None: ☒

MI:

IL:

OH:

References:

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State Letters/ Bulletins					
CMS National/Local Coverage Determination (NCD/LCD)					
Medicare Managed Care Manual:					
Medicaid CFR:					
State Administrative Codes:					
Contract Requirements:					
Related Policies:					