

Document ID#: 1035206  
Subject: Reduction Mammoplasty for Symptomatic Macromastia  
Effective Date: May 1, 2011

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	LPN

**Please Note: Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.**

### Overview

Reduction mammoplasty, also known as breast reduction surgery, is a surgical procedure to reduce the weight, mass and size of the breast.

**\*Please Note: These criteria may be used for bilateral or unilateral breast reduction surgery.**

### Coverage Guidelines

Tufts Health Plan may authorize coverage for Reduction Mammoplasty for members with **symptomatic macromastia** when they meet **both** of the following criteria:

- Members who submit a Letter of Medical Necessity, from their PCP or surgeon, which includes the member’s height and weight and the estimated grams of breast tissue to be removed from each breast.
- Members for whom the amount of breast tissue expected to be removed from each breast is at least as much as the amounts outlined in the chart below. (These criteria are adapted from the study reported in the Annals of Plastic Surgery by Paul Schnur et al. ‘Reduction Mammoplasty: Cosmetic or Reconstructive Procedure?’<sup>2</sup> The member’s body surface area will be calculated using the DuBois & DuBois Formula.

MEMBER’S BODY SURFACE AREA	AMOUNT TO BE REMOVED FROM: -EACH BREAST -Bilateral Procedure -SINGLE Breast -Unilateral Procedure (IN GRAMS)
1.35-1.58	200
1.59-1.75	300
1.76-1.87	400
1.88-1.97	500
1.98-2.06	600
2.07-2.13	700
2.14-2.20	800
2.21-2.27	900

2.28-2.32	1000
2.33-2.36	1100
2.37-2.40	1200
2.41-2.46	1300
2.47-2.52	1400
2.53-2.60	1500

Please note: You do not have to calculate the member's body surface area. Tufts Health Plan will calculate it from the member's height and weight using the Dubois & Dubois Formula.

## Limitations

- Reduction mammoplasty will not be covered for cosmetic purposes only.
- If a unilateral reduction is requested and authorized, augmentation or a contour change surgery of the contra lateral breast will not be covered.

## Codes

The following CPT code requires Prior Authorization:

Code	Description
19318	Reduction mammoplasty

## References

1. American Society of Plastic Surgeons (ASPS). Reduction mammoplasty. ASPS Recommended Coverage Criteria for Third Party Payors. Arlington Heights, IL: ASPS; March 9, 2002.
2. American Society of Plastic and Reconstructive Surgery, Socioeconomic Committee Position Paper: Recommended Criteria for Insurance Coverage of Reduction Mammoplasty. Arlington Heights, IL: ASPRS; 1987.
3. Boschert, M., et al. Outcome analysis of reduction mammoplasty. Plastic & Reconstructive Surgery. 1996; 98: 451-454.
4. Dabbah, A., Lehman, J., Parker M., Tantri, D., Wagner, D. Reduction mammoplasty: an outcome analysis.[comment]. Annals of Plastic Surgery. October 1995; 35(4):337-41.
5. Davis, G., Ringler S., Short, K., Sherrick, D., Bengtson, B.P. Reduction mammoplasty: long-term efficacy, morbidity, and patient satisfaction. Plastic & Reconstructive Surgery. 1996; 5:1106-10.
6. Letterman, G., Schurter, M. The effects of mammary hypertrophy on the skeletal system. Annals of Plastic Surgery. 1980; 5(6): 425-31.
7. Mosteller, R., Simplified calculation of body surface area. New England Journal of Medicine. 317(17): 1098. 1987.
8. Pri-Med. Medical Calculators.  
Available at: <http://www.pri-med.com/PMO/MedicalCalculatorsTab1.aspx>. Accessed on November 5, 2007.
9. Seitchik, M. Reduction mammoplasty: criteria for insurance coverage. [comment]. Plastic & Reconstructive Surgery. 1995; 6:1029-32.
10. Schnur, P., Hoehn, J., Ilstrup, D., Cahoy, M., Chu, C-P. Reduction mammoplasty: cosmetic or reconstructive procedure? Annals of Plastic Surgery. 1991; 27:232- 237.
11. Schnur, P., Schnur, D., et al. Reduction mammoplasty: an outcome study. Plastic & Reconstructive Surgery. 1997;100: 875-83.
12. Thanh, T.V. Standardization of body surface area calculations. Journal of Oncology Pharmacy Practice. 2002; 8(2-3): 49-54.
13. DuBois D, DuBois EF. A formula to estimate the approximate surface area if height and weight be known. Arch Intern Medicine. 1916; 17:863-71.

## Approval History

Reviewed by the Clinical Coverage Criteria Committee in February 1999.

Subsequent Endorsement Date(s) and Changes Made:

- October 2001: Renewed, no changes.
- May 2002: Renewed, no changes.
- August 2002: Requirement of PCP letter of medical necessity removed. The letter may be sent by the member's PCP or attending physician.
- May 2003: Updated to new format, 'Reduction Mammoplasty Worksheet' removed from guideline.
- August 5, 2003: Reviewed and renewed. The chart used in the criteria was changed from 'Minimal Amount of Breast Tissue to be removed for Each Breast', which uses the member's height only to a chart that uses the member's body surface area as a guide. References were added. Definition of skin diseases was added.
- January 9, 2004: The Medical Necessity Guidelines for this procedure have been changed. The Tufts Health Plan Clinical Coverage Criteria Committee has determined that the Schnur criteria, as referenced above, are the only criteria for this procedure.
- January 7, 2005: Reviewed and renewed without changes.
- January 13, 2006: Reviewed and renewed without changes.
- March 15, 2007: Reviewed and renewed, coding added.
- March 26, 2008: Reviewed. BSA calculator changed from the Du Bois & Du Bois Formula to the Mosteller Formula based on new literature review. Limitation stating that this procedure will not be covered for cosmetic purposes was added.
- May 4, 2009: Reviewed and renewed without changes.
- December 2009: Clarification that MNG may be for bilateral or unilateral reduction added; BSA calculation formula changed from Mosteller Formula to DuBois & DuBois formula; limitation of contra lateral breast surgery added.
- March 2009: Title change: Symptomatic Macromastia added.
- April 2010: Reviewed at MSPAC, no changes.
- April 2011: Reviewed at MSPAC. No changes.

## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink<sup>SM</sup>.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.