Medical Policy
Reduction Mammaplasty for Breast-Related Symptoms

Table of Contents
- Policy: Commercial
- Coding Information
- Information Pertaining to All Policies
- Policy: Medicare
- Description
- References
- Authorization Information
- Policy History
- Endnotes

Policy Number: 703
BCBSA Reference Number: 7.01.21
NCD/LCD: Local Coverage Determination (LCD): Reduction Mammaplasty (L35001)

Related Policies
- Surgical Treatment of Gynecomastia, #661

Policy¹
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Reduction mammoplasty may be considered MEDICALLY NECESSARY for the treatment of macromastia when the following well-documented clinical symptoms are present AND if a member is under age 18, the following age criteria must also be met:

Age Criteria:
- Documented tanner stage IV or V for members aged 15-18, AND
- Stable height measurements for 6 months, OR
- Puberty completion as shown on wrist radiograph.

Clinical Symptoms:
- Documentation of a minimum 6-week history of shoulder, neck, or back pain related to macromastia that is not responsive to conservative therapy, such as an appropriate support bra, exercises, heat/cold treatment, and appropriate nonsteroidal anti-inflammatory agents/muscle relaxants. This includes documentation of the presence of shoulder grooving, an indication that the breast weight results in grooving of the bra straps on the shoulder, OR
- Recurrent or chronic intertrigo between the pendulous breast and the chest wall that is resistant to topical treatment.

Patients meeting the above criteria should have either a minimum of 500g per breast removed OR the surgeon should follow the below Schnur sliding scale, which suggests a minimum amount of breast tissue removed based on a patient’s body surface area if the planned weight to be resected from each breast falls below 500g.
Body Surface Area (m²)* and Weight of Breast Tissue Removed [per breast]

<table>
<thead>
<tr>
<th>Body Surface Area (m²)</th>
<th>Minimum Grams of Breast Tissue to be Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.35</td>
<td>199</td>
</tr>
<tr>
<td>1.40</td>
<td>218</td>
</tr>
<tr>
<td>1.45</td>
<td>238</td>
</tr>
<tr>
<td>1.50</td>
<td>260</td>
</tr>
<tr>
<td>1.55</td>
<td>284</td>
</tr>
<tr>
<td>1.60</td>
<td>310</td>
</tr>
<tr>
<td>1.65</td>
<td>338</td>
</tr>
<tr>
<td>1.70</td>
<td>370</td>
</tr>
<tr>
<td>1.75</td>
<td>404</td>
</tr>
<tr>
<td>1.80</td>
<td>441</td>
</tr>
<tr>
<td>1.85</td>
<td>482</td>
</tr>
<tr>
<td>1.90</td>
<td>527</td>
</tr>
</tbody>
</table>

*Calculation of Body Surface Area (BSA)
- Mosteller formula: Body surface area = the square root of height (cm) multiplied by weight (kg) divided by 3,600.
- To convert pounds to kilograms, multiply pounds by 0.45
- To convert inches to meters, multiply inches by 0.0254

Click the hyperlink for an online BSA calculator: [http://www.medcalc.com/body.html](http://www.medcalc.com/body.html)
Please use the Mosteller formula option with the above tool (available after data is entered).

**Note:** The scale above is taken from the Schnur Sliding Scale and shows the BSA and associated grams of breast tissue to be removed to meet the 22nd percentile where women are likely to have a reduction mammoplasty primarily for medical reasons.

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

**Medicare HMO BlueSM and Medicare PPO BlueSM Members**

Medical necessity criteria and coding guidance for Medicare Advantage members living in **Massachusetts** can be found through the link below.

Local Coverage Determination (LCD): Reduction Mammaplasty (L35001)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of **Massachusetts**, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at [https://www.cms.gov](https://www.cms.gov).

**Prior Authorization Information**

Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.
Outpatient

| Commercial Managed Care (HMO and POS) | Yes |
| Commercial PPO and Indemnity  | No |
| Medicare HMO BlueSM  | Yes |
| Medicare PPO BlueSM  | No |

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19318</td>
<td>Reduction mammaplasty</td>
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ICD-10 Procedure Codes

<table>
<thead>
<tr>
<th>ICD-10-PCS procedure codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>0HBT0ZZ</td>
<td>Excision Of Right Breast, Open Approach</td>
</tr>
<tr>
<td>0HBT3ZZ</td>
<td>Excision Of Right Breast, Percutaneous Approach</td>
</tr>
<tr>
<td>0HBU0ZZ</td>
<td>Excision Of Left Breast, Open Approach</td>
</tr>
<tr>
<td>0HBU3ZZ</td>
<td>Excision Of Left Breast, Percutaneous Approach</td>
</tr>
<tr>
<td>0HBV0ZZ</td>
<td>Excision Of Bilateral Breast, Open Approach</td>
</tr>
<tr>
<td>0HBV3ZZ</td>
<td>Excision Of Bilateral Breast, Percutaneous Approach</td>
</tr>
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</table>

Description

Reduction mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue.

Background

Macromastia, or gigantomastia, is an ill-defined term 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 mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or relieve the associated clinical symptoms.

Summary

Reduction mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue. The available evidence from randomized controlled and prospective studies indicates that reduction mammaplasty 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 following reduction mammaplasty. Therefore, the available evidence for reduction mammaplasty is sufficient to demonstrate improvements in net health outcome. Reduction mammaplasty may be considered medically necessary in patients with macromastia, who have a minimum 6-week history of shoulder, neck, or back...
pain that is not responsive to conservative therapy, and not caused by any other identifiable condition. Reduction mammaplasty may also be considered medically necessary in patients with recurrent or chronic intertrigo between the pendulous breast and the chest wall.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>3/2017</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>7/2016</td>
<td>Medically necessary statement clarified. 7/1/2016.</td>
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<tr>
<td>11/2015</td>
<td>Age minimum for breast reduction revised from 18 to 15 years old.</td>
</tr>
<tr>
<td></td>
<td>Medically necessary guidelines revised to include evidence that puberty is complete for breast augmentation. Clarified coding information. Effective 11/1/2015.</td>
</tr>
<tr>
<td>1/2015</td>
<td>BCBSA National medical policy review.</td>
</tr>
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<td></td>
<td>Investigational language clarified. Effective 1/1/2015.</td>
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**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

**References**


**Endnotes**

1 Based on MPRM No. 7.01.21 and expert opinion