BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Breast Reduction Surgery

Policy Number: OCA 3.44
Version Number: 23
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☒ NH Medicaid	☒ MassHealth ACO
☒ NH Medicare Advantage	☒ MassHealth MCO
	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Breast reduction surgery (reduction mammoplasty) is considered **medically necessary** for symptomatic macromastia when Plan criteria are met. Plan prior authorization is required. If applicable medical criteria are NOT met, the surgery is considered cosmetic.

The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition. Review the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.12 for guidelines on the use autologous fat grafts to treat HIV-associated lipodystrophy syndrome according to Massachusetts mandated benefits, as specified in Chapter 233 of the Acts of 2016, An Act Relative to HIV Associated Lipodystrophy Syndrome Treatment. Other applicable medical policies include: *Breast Reconstruction Surgery* medical policy, policy number OCA 3.43; *Gender Affirmation Services* medical policy, policy number OCA 3.11; *Gynecomastia Surgery* medical policy OCA 3.48; and *Mastopexy* medical policy, policy number OCA 3.717.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

Clinical Criteria

The Plan considers breast reduction surgery (reduction mammoplasty) to be medically necessary for symptomatic macromastia or when the procedure is related to breast reconstruction after lumpectomy or mastectomy for a female member (or a member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes). The treating provider should discuss with the member **breast feeding considerations** related to breast reduction mammoplasty as a component of the evaluation for surgery. The treating provider must verify that the member is an acceptable surgical candidate (with evaluation of the member's high-risk indicators, if any, such as morbid obesity, tobacco use, cardiac history, comorbidities, and related past medical/surgery history). The Plan's applicable medical necessity criteria must be met for reduction mammoplasty and documented in the member's medical record (including preoperative photographs, which will be submitted as part of the prior authorization review process if requested by the Plan), as specified below in EITHER item 1 or item 2:

1. **Breast Reduction Surgery (Reduction Mammoplasty) for Breast Hypertrophy, Gigantomastia, or Macromastia:**

   ALL of the following criteria must be met, as specified below in items a through f:

   a. Age Criteria:

      ONE (1) of the following applicable criteria is met, as specified below in item (1) or item (2):

      (1) Pediatric member is 15-17 years of age on the date of service and the following criteria are met for the female pediatric member (or a pediatric member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes‡), as specified below in items (a) through (c):

         (a) Documented Tanner stage IV or stage V (full physical maturity); AND

         (b) Breast/cup size has been stable for at least 6 consecutive calendar months prior to surgery; AND

         (c) At least ONE (1) of the following growth parameters is met, as specified below in item i or item ii:

            i. Stable height measurements for at least 6 consecutive calendar months prior to surgery; AND/OR

            ii. Wrist radiograph has confirmed the completion of puberty prior to surgery; OR

(2) Adult female member (or an adult member born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes‡) is age 18 or older on the date of service; AND

‡ Note: The Plan will review requests for breast reconstruction procedures for gender reassignment using the medical criteria included in the *Gender Affirmation Services* medical policy, policy number OCA 3.11, rather than other Plan medical policies related to the requested breast procedure.

b. Member has a diagnosis of symptomatic breast hypertrophy, gigantomastia, or macromastia and the estimated minimum weight of excess breast tissue per breast and the amount of total body surface area (BSA) in square meters (m^2) to be removed meets ONE (1) of the following criteria, as specified below in items (1) through (4):

(1) 199 grams to 238 grams of tissue per breast to be removed with BSA 1.35 to 1.45 m^2; OR

(2) 239 grams to 284 grams of tissue per breast to be removed with BSA 1.46 to 1.55 m^2; OR

(3) 285 grams to 349 grams of tissue per breast to be removed with BSA 1.56 to 1.69 m^2; OR

(4) 350 grams or greater of tissue per breast to be removed; AND

c. The treating provider has determined that the member has a reasonable prognosis of symptomatic relief after reduction mammoplasty; AND

d. Documentation includes at least TWO (2) of the following clinical findings, as specified below in items (1) through (8):

(1) Symptoms of persistent pain in the upper back, neck, and/or shoulders that have interfered with activities of daily living for at least 6 calendar months within the past 12 consecutive months prior to this prior authorization request, and pain is unresponsive to conservative treatments for at least 3 calendar months that include but are not limited to physical therapy and pharmacotherapies (e.g., anti-inflammatories and analgesics);

(2) Intractable cervicodorsal myositis (i.e., inflammation of the back and neck muscles) for at least six (6) calendar months and the condition is unresponsive to medical therapy;

(3) Tissue ulcerations, dermatitis (e.g., intertrigo), and/or eczema of the inframammary fold are unresponsive to dermatological treatment;

(4) Upper extremity paresthesia due to brachial plexus compression syndrome;

(5) Painful and permanent shoulder grooving (defined as deep grooves in the shoulder with pain and discomfort from bra straps) despite the use of a support bra with weight distributing straps;

(6) Gigantomastia in pregnancy when delivery is not imminent;

(7) Chronic breast pain (defined as breast pain lasting six [6] calendar months or longer) due to breast weight that is unresponsive to conservative treatments such as support garments;

(8) Painful thoracic kyphosis documented by radiographs; AND

e. Comorbid etiologies of the member's symptoms (as specified above) have been ruled out (i.e., combination of medical conditions/risk factors that may increase the occurrence of macromastia and associated symptoms); AND

f. Member 40 years of age or older has had a mammogram within 12 calendar months from the date of the planned reduction mammoplasty that was negative for cancer in both breasts;≈ OR

≈ Note: All female members (or members born with female reproductive organs and/or with typical female karyotype with two [2] X chromosomes) under the age of 40 who are symptomatic or have an associated high-risk factor for breast cancer should be screened prior to breast reduction surgery.

2. **Reduction Mammoplasty as Part of Breast Reconstruction after Mastectomy or Lumpectomy:**

BOTH of the following criteria must be met for a member after a diagnosis of breast cancer, as specified below in item a and item b:

a. Reduction mammoplasty will be performed to reduce the size of an unaffected breast to bring it into symmetry with a breast reconstructed after mastectomy or lumpectomy (either oncoplastic reduction mammoplasty or reduction mammoplasty following mastectomy or lumpectomy); AND

b. Member has had a mammogram within 12 calendar months from the date of the planned reduction mammoplasty that was negative for cancer, including the unaffected side if used to create symmetry after breast surgery related to breast cancer (unless oncoplastic reduction mammoplasty is performed concurrently with the breast surgery related to breast cancer treatment and then the criterion requiring a mammogram negative for cancer would not be applicable).

Limitations and Exclusions

ANY of the following limitations applies to breast reduction surgery (reduction mammoplasty), as specified below in items 1 through 4:

1. The Plan considers suction assisted lipectomy or liposuction as a sole method of surgical treatment for reduction mammoplasty to be cosmetic and NOT medically necessary.

2. Breast reduction surgery is considered cosmetic (and NOT medically necessary) for poor posture, breast asymmetry, pendulousness, problems with clothes fitting properly, nipple-areola distortion, and/or psychological considerations when the Plan's applicable clinical review criteria specified in the Clinical Criteria section of this policy are NOT met. Any request for breast reduction surgery that does NOT meet the Plan's medical necessity criteria requires individual consideration by a Plan Medical Director.

3. A request for breast reduction surgery for a member age 13 or age 14 on the date of service requires Medical Director review with documentation that the member's breast/cup size has been stable for at least 6 consecutive calendar months, as well as documentation that all other applicable medical necessity criteria are met.

4. Repeat reduction mammoplasty is NOT considered medically necessary unless there are complications resulting from the initial procedure. Plan Medical Director review is required for individual consideration.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, CMS NCD 140.2 includes nationally covered indications for breast reconstruction following mastectomy and LCD L35001 includes guidelines for reduction mammaplasty. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at

different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria and Limitations and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Code Covered When Medically Necessary
19318	Breast reduction

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/06/05	06/09/06 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/16

Policy title was *Breast Reduction Mammoplasty in Females* from 06/09/16 to 10/31/16. The policy title was *Breast Reduction Mammoplasty* from 11/01/16 to 12/31/20. As of 01/01/21, the policy title has been changed to *Breast Reduction Surgery*.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
05/09/06	Removed the requirement for a pre-operative mammogram to be submitted prior to authorization.	Version 2	05/09/06: Q&CMC
05/08/07	Updated clinical criteria, template, added coding, and references.	Version 3	06/14/07: MPCTAC 06/26/07: Utilization Management Committee (UMC) 07/12/07: Quality Improvement Committee (QIC)
05/13/08	Added information on how to calculate the BSA based upon the DuBois Formula.	Version 4	05/13/08: MPCTAC 05/20/08: UMC 05/28/08: QIC
05/26/09	Clarified clinical criteria for shoulder grooving.	Version 5	05/26/09: MPCTAC 05/26/09: UMC 06/24/09: QIC

Policy Revisions History			
05/01/10	No criteria changes. Updated references.	Version 6	05/25/10: MPCTAC 06/23/10: QIC
05/01/11	No criteria changes. Updated references and coding.	Version 7	05/18/11: MPCTAC 06/22/11: QIC
05/01/12	Note added at end of Clinical Background Information related to a patient considering both bariatric surgery and reduction mammoplasty. References updated.	Version 8	05/16/12: MPCTAC 06/27/12: QIC
07/30/12	Off cycle review for Well Sense Health Plan. Reformatted Clinical Guideline Statement and revised references.	Version 9	08/03/12: MPCTAC 09/05/12: QIC
04/01/13	Review for effective date of 08/01/13. Revised Summary, Description of Item or Service, and Clinical Background Information sections. Revised language in introductory paragraph of Applicable Coding section. Revised and added limitations. Updated criteria in Medical Policy Statement section (formerly titled Clinical Guideline Statement section). Moved definition of Schnur Sliding Scale from Clinical Background Information section to the Definitions section. Added text to gigantomastia definition. Referenced the following Plan policies: Medically Necessary, Mastopexy, Breast Reconstruction, Bariatric Surgery, Gynecomastia Surgery, and Cosmetic, Reconstructive, and Restorative Services. Updated references. Changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy."	08/01/13 Version 10	04/17/13: MPCTAC 05/16/13: QIC
06/01/13	Review for effective date of 09/01/13. Revised text in Medical Policy Statement section. Deleted CPT code 15877 from applicable code list.	09/01/13 Version 11	06/19/13: MPCTAC 07/18/13: QIC
04/01/14	Review for effective date 08/01/14. Revised Medical Policy Statement section. Updated the definition of the Schnur Sliding Scale and the References section.	08/01/14 Version 12	04/16/14: MPCTAC 05/14/14: QIC
04/01/15	Review for effective date 06/01/15.	06/01/15	04/15/15: MPCTAC

Policy Revisions History			
	Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Updated Summary, Definitions, and References sections. Added to the Medical Policy Statement section that preoperative photographs may be required upon request during the Plan prior authorization process.	Version 13	05/13/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 14	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 06/01/16. Revised the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	06/01/16 Version 15	04/20/16: MPCTAC 05/23/16: QIC
09/28/16	Review for effective date 11/01/16. Revised policy title and made administrative changes to clarify language related to gender.	11/01/16 Version 16	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
04/01/17	Review for effective date 05/08/17. Administrative changes made to the Medical Policy Statement section. Updated Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	05/08/17 Version 17	04/19/17: MPCTAC
05/01/18	Review for effective date 06/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, References, and Other Applicable Policies sections.	06/01/18 Version 18	05/16/18: MPCTAC
04/01/19	Review for effective date 05/01/19. Administrative changes made to the Limitations, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	05/01/19 Version 19	04/18/19: MPCTAC (electronic vote)

Policy Revisions History			
04/01/20	Review for effective date 07/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections.	07/01/20 Version 20	04/15/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Industry-wide update to code descriptions in the Applicable Coding section. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, and Limitations sections. Updated the policy title.	01/01/21 Version 21	Not applicable because industry-wide code changes; 12/16/20: MPCTAC review
05/01/21	Review for effective date 08/01/21. Administrative changes made to the Policy Summary, Definitions, Limitations, and References sections. Criteria revised in the Medical Policy Statement section.	08/01/21 Version 22	05/19/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary and References sections.	12/01/21 Version 23	11/17/21: MPCTAC

Next Review Date

04/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as

the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.