

MEDICA®

UTILIZATION MANAGEMENT POLICY

TITLE: FEMALE BREAST REDUCTION SURGERY – REDUCTION MAMMOPLASTY

Origination Date: June, 2005

Subsequent Endorsement Date(s): 06/2006, 06/2007, 06/2008, 06/2009, 06/2010

This policy was developed with input from specialists in plastic surgery and general surgery, and endorsed by the Medical Policy Committee.

PRODUCT APPLICATION

This policy provides general information concerning Medica's administrative processes. It applies to all fully insured Medica Health Plans, Medica Insurance Company, and Medica Health Plans of Wisconsin products, unless a specific limitation or exception exists. For self-insured plans, consult individual plan sponsor benefit documents. If there is a discrepancy between a Utilization Management Policy and a self-insured benefit plan, the provisions of the benefit plan will govern. With respect to Medicare and Medicaid members, this policy will apply unless Medicare or Medicaid policies require different coverage.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

Medica updates its Utilization Management Policies regularly, and reserves the right to amend these policies without notice to Medica members. Medica also reserves the right to amend these policies without notice to contracted health care providers unless the amendment materially alters the policy. If the amendment materially alters the policy, Medica will disclose the change to contracted health care providers not less than 45 days prior to implementation of the policy. Medica's Utilization Management Policies contain general information only and do not guarantee coverage. Receipt of benefits is subject to all terms and conditions of the member's coverage document. Members should consult their Certificates of Coverage or Plan Documents/Summary Plan Descriptions to review the provisions relating to a specific coverage determination. If there is a conflict between a Utilization Management Policy and the applicable coverage document, the coverage document will govern. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Utilization Management Policy may call Medica's Provider Service Center toll free at 1-800-458-5512.

Medica's Utilization Management Policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing criteria that generally determine the medical necessity of female breast reduction surgery. The Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

I. Definitions

- A. **Mammary hyperplasia (macromastia)** is the development of abnormally large breasts. Macromastia is distinguished from large, normal breasts by the presence of persistent, painful symptoms and physical signs.
- B. **Reduction mammoplasty** is surgical excision of mammary tissue and repositioning of the areola and nipple.
- C. **Intertriginous rash** results from dermatitis occurring between juxtaposed folds of skin. The dermatitis is usually caused by retention of sweat, moisture, and warmth which results in an overgrowth of normal skin microorganisms.
- D. **Cellulitis** is an acute spreading bacterial infection (usually *Staphylococcus aureus* or Group A *Streptococcus*) in the deeper layers of the skin (i.e., the dermis and subcutaneous tissues). It is characterized by erythema, warmth, swelling, pain, fever, and malaise. Cellulitis commonly appears in areas where there is a break in the skin from an abrasion, a cut, or skin ulceration. Standard treatment is antibiotic therapy.

- E. **Necrosis** is the death of living cells and tissue. Necrosis is caused by localized tissue injury, such as corrosion or erosion, a lesion or ulceration, or loss of blood supply.
- F. A **skin ulceration** is a break in the skin with accompanying loss of surface tissue with disintegration and necrosis of underlying tissue.

II. Comments

- A. Member demand exists for reduction mammoplasty in the absence of functional signs and symptoms, solely to improve the member's perception of their appearance.
- B. The factors that distinguish appearance-related requests from medically necessary requests are symptoms and physical findings caused by excess breast tissue mass.

MEDICAL NECESSITY CRITERIA

I. Indications

All of the following criteria must be met:

- A. Patient is at least 18 years of age. Women 40 years of age or older are required to have a mammogram that was negative for cancer within the year prior to the date of the planned procedure.

AND

- B. Expected tissue removal of at least:
 - 1. 300 grams per breast for women with height less than 5'2" or weight less than 120 lbs.
 - 2. 400 grams per breast for women with height greater than or equal to 5'2" and weight between 120 lbs. and 180 lbs.
 - 3. 600 grams per breast for women with height greater than or equal to 5'2" and weight greater than 180 lbs.

NOTE: If significant asymmetry exists, the grams of tissue to be removed from at least one breast must comply with the criteria outlined above.

AND

- C. There is a documented history of macromastia with at least **two** of the following functional impairments, present for six months or greater:
 - 1. Persistent shoulder grooving
 - 2. Chronic submammary intertriginous rash causing cellulitis, skin necrosis, and/or ulceration unresponsive to dermatologic treatment (i.e., antibiotics or antifungal therapy)
 - 3. Neurologic symptoms related to brachial plexus pressure and/or ulnar paresthesia
 - 4. Chronic neck, back, and shoulder pain and/or occipital headaches.

II. Written documentation from the medical record may be required, including but not limited to:

- A. Patient's height and weight
- B. Documentation of signs, symptoms, and clinical indications verifying medical necessity, according to the above criteria
- C. Provider estimate of grams of tissue to be removed
- D. Photographs may be submitted, but are not required.

COVERAGE ISSUES

- 1. Prior authorization **is required** for breast reduction surgery.
- 2. Coverage may vary according to the terms of the member's coverage document.
- 3. For Medicare members, refer to the following criteria, as applicable:
 - Centers for Medicare and Medicaid Services (CMS). *National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2)*. Available at: http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=140.2&ncd_version=1&basket=ncd%3A140%2E2%3A1%3ABreast+Reconstruction+Following+Mastectomy. Accessed April 14, 2010.
 - For Minnesota: Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD)*

for *Cosmetic and Reconstructive Surgery (L17996)*. Available at:
http://www.cms.gov/mcd/viewlcd.asp?lcd_id=17996&lcd_version=18&basket=lcd%3A17996%3A18%3ACosmetic+and+Reconstructive+Surgery%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800954%29%3A. Accessed May 3, 2010.

- For Wisconsin: Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD) for Cosmetic and Reconstructive Surgery (L17993)*. Available at:
http://www.cms.gov/mcd/viewlcd.asp?lcd_id=17993&lcd_version=20&show=all. Accessed May 3, 2010.
 - For North Dakota and South Dakota: Noridian Administrative Services, LLC. *Local Coverage Determination (LCD) for Plastic Surgery (L24349)*. Refer to the Medicare Coverage Database Search Page, available at:
<http://www.cms.hhs.gov/mcd/search.asp>? Accessed April 14, 2010.
 - For other states, refer to the Medicare Coverage Database Search Page, available at:
<http://www.cms.hhs.gov/mcd/search.asp>?
4. Cosmetic surgery is generally an exclusion in the member's coverage document. However, coverage of all stages of reconstruction of the breast on which a mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance is required by state and federal law.
 5. The use of liposuction to perform breast reduction is considered cosmetic and therefore excluded from coverage.
 6. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's coverage document.
 7. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeals process in their Medica administrative handbook.
 8. Refer to Medica's Coverage Policy, *Gynecomastia Surgery*, for coverage of surgery for male breast enlargement.

References:

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http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Evidence-based_GuidelinesPractice_Parameters.html. Accessed April 14, 2010.
2. Antoniuk P. Breast Augmentation and Breast Reduction. *Obstet Gynecol Clin North Am*. March 2002;29(1):103-115.
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4. Centers for Medicare and Medicaid Services (CMS). *National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2)*. Available at:
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5. Chadbourne EB, Zhang S, Gordon MJ, et al. Clinical outcomes in reduction mammoplasty: A systematic review and meta-analysis of published studies. *Mayo Clin Proc*. May 2001;76:503-510.
6. Cunningham BL, Gear AJ, Kerrigan CL, Collins ED. Analysis of breast reduction complications derived from the BRAVO study. *Plast Reconstr Surg*. 2005;115(6):1597-1604.
7. ECRI Institute. *ECRI Custom Hotline Response: Female Breast Reduction Surgery*. June 14, 2005. Plymouth Meeting, PA.
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10. Noridian Administrative Services, LLC. *Local Coverage Determination (LCD) for Plastic Surgery (L24349)*. Refer to the Medicare Coverage Database Search Page, available at: <http://www.cms.hhs.gov/mcd/search.asp>? Accessed April 14, 2010.
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13. Saarniemi KMM, Keranen UH, Salminen-Peltola PK, Kuokkanen HOM. Reduction mammoplasty is effective treatment according to two quality of life instruments. A prospective randomised clinical trial. *J Plast Reconstr Aesthet Surg*. December 2008;61(12):1472-1478.
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16. Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD) for Cosmetic and Reconstructive Surgery (L17996)*. Available at: http://www.cms.gov/mcd/viewlcd.asp?lcd_id=17996&lcd_version=18&basket=lcd%3A17996%3A18%3ACosmetic+and+Reconstructive+Surgery%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800954%29%3A. Accessed May 3, 2010.
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