

Meeting: Utilization Management Committee	Date: 12/12/2024
Title/Topic: Medical Policy-Reduction Mammoplasty	Policy Number: n00229
Purpose: Annual Review	Outcome: Accept as proposed
Line of Business: Commercial	Effective Date: 12/12/2024

INTRODUCTION:

Includes definition of problem or opportunity. Provides background information on the topic. Describes current state. May also include prior state and/or factors that have changed. Includes operational definitions where key terms may have varied interpretation.

Reduction mammoplasty is the surgical reconstruction of the breast to reduce size and weight of mammary tissues.

This medical policy provides guidance for Utilization Management Coordinator Registered Nurses (UMC-RN) regarding determinations involving the medical necessity of Reduction Mammoplasty Services. This policy is due for annual review.

ACTION RECOMMENDED:

States recommendations in specific terms. Includes a summary of what should be accomplished, methods, and timetable (if applicable). Recommendations on implementation and follow-up plans may also be included.

Annual review has been conducted and the Reduction Mammoplasty medical policy is presented for review and approval with changes as written.

No changes were made to the content or utilization guidance of this policy. Changes made include updating references, grammatical updates, and verification of CPT codes.

ANALYSIS/JUSTIFICATION:

Includes information relevant to the recommended action including information used in formulation the recommendations. Information will include reference to any existing Centers for Medicare & Medicaid Services (CMS) coverage determinations as well as any existing established vendor criteria. Information may include financial/cost data, service measures, projections or other key measures or process tools, recommendations from a clinical provider with expertise regarding the topic, and/or information from other widely used treatment guidelines or peer reviewed clinical literature.

The Centers for Medicare/Medicaid (CMS) has guidance. Local Coverage Determination (LCD) L35001 Reduction Mammoplasty outlines the medical necessity criteria for Medicare members.

MCG, Ambulatory Care 28th Edition-Reduction Mammoplasty (Mammoplasty) A-0274 has indications for reduction mammoplasty when breast size interferes with activities of daily living, a pre-op evaluation by surgeon concludes that the amount of breast tissue to be removed with provide reasonable expectation of symptom relief and there is no evidence of breast cancer. There are no recommendations provided related to what would be the appropriate amount of tissue to be removed to provide symptom relief. There is also no minimum age recommendation.

REFERENCES:

Includes detailed description regarding source(s) of information used for development of policy or recommendations via citation.

- CMS Medicare Local Coverage Determination, Reduction Mammoplasty, L35001, effective 10/01/20215 with revisions 02/01/2024.
- DuBois, D, DuBois EF. A Formula to Estimate the Approximate Surface Area if Height and Weight be Known. Arch Int Med. 1916;17:863-871
- Hansen, J, Chang, S. Overview of Breast Reduction. Up to Date. January 2/17/2021
- MCG Ambulatory Care 28th Edition, Reduction Mammoplasty A-0274
- Schnur PL, Hoehn JG, Listrup DM, Chaoy MJ, Chu C. Reduction Mammoplasty: Cosmetic or Reconstructive Procedure? Ann Plast Surg. 1991;27:232-237.

REVISION REASON:

Includes the date changes or updates were made and summary of changes applied.

12/12/2024 Annual Review; Changes made include updating references, grammatical updates, and verification of CPT codes.

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy.

Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.