Medical Policy Manual Surgery, Policy No. 60

Reduction Mammaplasty

Effective: November 1, 2026

Next Review: July 2027
Last Review: June 2026

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Reduction mammaplasty is the surgical excision of a substantial portion of the breast, including the skin and underlying glandular tissue, until a clinically normal size is obtained.

MEDICAL POLICY CRITERIA

Notes:

- This policy is not applicable when there has been a prior mastectomy for which the Women's Health & Cancer Rights Act applies. The Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants policy (Surgery, Policy No. 40 – see Cross References) may be applicable. Please refer to the Surgery, Policy No. 40 for reconstruction after partial or complete mastectomy.
- This policy is not intended to address treatment of gender dysphoria which is addressed in the Transgender Services medical policy (Medicine, Policy No. 153 – see cross references), which may be applicable.
- Clinical documentation to support criteria is required (See Required Documentation)

Medically Necessary

I. Reduction mammaplasty may be considered **medically necessary** when one or more of the following are met:

A. As a preparatory first stage procedure preceding a nipple-sparing mastectomy, when the amount of breast tissue removed from each breast is at least the minimum in grams per breast for the patient's body surface area (in meters squared using the Mosteller formula) according to the Schnur Sliding Scale (see Policy Guidelines for body surface area/breast weight table); or

B. When all of the following criteria (1. - 3.) are met:

1. The individual meets one of the following:

a. Age 18 years or older; or

b. Age 16 years or older and both of the following are met:

i. Breast size has been stable for at least 12 months; and

ii. The provider has documented why intervention before age 18 is medically necessary.

2. The amount of breast tissue removed from each breast, not including fat removed by liposuction, must be at least the minimum in grams per breast for the patient's body surface area* according to the Schnur Sliding Scale (see Policy Guidelines), or, in cases of asymmetry where one breast meets criterion but the other breast does not, the combined weight of the tissue removed from both breasts must total at least twice the Schnur Sliding Scale minimum for the patient's body surface area (the health plan may review medical records to confirm the amount of breast tissue removed during the procedure); and

3. The individual has one or more of the following clinical indications:

a. Pain in the upper back, neck, shoulders, and/or arms, with all of the following documented in the medical records by the referring provider (not the surgeon) (see Required Documentation below):

i. The pain has been present for at least 12 months; and

ii. A clinical evaluation has been performed to determine that the pain is not secondary to any other identifiable condition; and

iii. The pain is not relieved by at least three months of conservative therapy such as an appropriate support bra with wide straps, exercises, heat/cold treatments and appropriate non-steroidal anti-inflammatory agents or muscle relaxants.

b. Intertrigo between the pendulous breasts and the chest wall persisting despite at least three months of conservative dermatologic treatments (e.g., taking steps to eliminate friction, heat, and maceration by keeping skin cool and dry and where appropriate, antimycotic agents).

c. Kyphosis documented by x-ray.

d. Ulnar paresthesia not relieved by at least three months of conservative therapy such as an appropriate support bra with wide straps, range of

motion exercises, physical therapy, and appropriate non-steroidal anti-inflammatory agents/muscle relaxants.

Not Medically Necessary

II. Reduction mammaplasty is considered **not medically necessary** when Criteria I. is not met.

III. Reduction mammaplasty for gynecomastia is considered **not medically necessary**.

IV. The use of liposuction as an additional procedure with breast reduction surgery is considered **not medically necessary**.

Investigational

V. The use of liposuction as the sole procedure for breast reduction is considered **investigational**.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

REFERRING PROVIDERS

The referring provider should be a designated health care professional, such as a medical doctor, osteopathic physician, or nurse practitioner, who is licensed to perform a complete medical examination. This does not include chiropractors, physical therapists, or massage therapists (see health plan benefits for additional information regarding providers).

SCHNUR SCALE

Mosteller formula: body surface area (m^2) = ([height (cm) x weight (kg)] / 3600)^{½} [1]

Click here for link to Body Surface Area Calculator

Schnur Sliding Scale

Body Surface Area (m^2) and Minimum Requirement for Breast Tissue Removal	
Body Surface Area m^2	**Grams per Breast of Minimum Breast Tissue to be Removed**
NOTE: When BSA is < 1.350 minimum is 199 grams	
1.350-1.374	199
1.375-1.399	208
1.400-1.424	218
1.425-1.449	227
1.450-1.474	238

1.475-1.499	249
1.500-1.524	260
1.525-1.549	272
1.550-1.574	284
1.575-1.599	297
1.600-1.624	310
1.625-1.649	324
1.650-1.674	338
1.675-1.699	354
1.700-1.724	370
1.725-1.749	386
1.750-1.774	404
1.775-1.799	422
1.800-1.824	441
1.825-1.849	461
1.850-1.874	482
1.875-1.899	504
1.900-1.924	527
1.925-1.949	550
1.950-1.974	575
1.975-1.999	601
2.000-2.024	628
2.025-2.049	657
2.050-2.074	687
2.075-2.099	717

2.100-2.124	750
2.125-2.149	784
2.150-2.174	819
2.175-2.199	856
2.200-2.224	895
2.225-2.249	935
2.250-2.274	978
2.275-2.299	1022
2.300-2.324	1068
2.325-2.349	1117
2.350-2.374	1167
2.375-2.399	1219
2.400-2.424	1275
2.425-2.449	1333
2.450-2.474	1393
2.475-2.499	1455
2.500-2.524	1522
2.525-2.549	1590
2.550 or greater	1662

REQUIRED DOCUMENTATION

It is critical that the list of information below is submitted for review to determine if the policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

1. Total amount of breast tissue to be removed, include if L/R or bilateral
2. Height and weight
3. Any of the following detailed in chart notes, history and physical, physical therapy notes, radiologic exams, dermatology treatments notes, and/or any other clinical notes:
    A. Medical records by the primary care provider related to pain in the upper back, neck, shoulders and/or arms. This should include documentation of long-standing

pain and evaluation for other conditions that may be the source of the pain, as well as detailed notes regarding treatment with at least three months of conservative therapy;

B. Intertrigo despite three months detailed documentation of conservative therapy;
C. X-ray showing kyphosis;
D. Ulnar paresthesia despite three months documentation of conservative therapy and outcome with chart notes detailing specific treatment.

CROSS REFERENCES

1. Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. 153
2. Cosmetic and Reconstructive Surgery, Surgery, Policy No. 12
3. Mastectomy as a Treatment of Gynecomastia, Surgery, Policy No. 12.06
4. Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants, Surgery, Policy No. 40
5. Autologous Fat Grafting to the Breast and Adipose-derived Stem Cells, Surgery, Policy No. 182

BACKGROUND

Female breast hypertrophy, or macromastia, is the development of abnormally large breasts in the female. This condition can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk. Macromastia is distinguished from large, normal breasts by the presence of persistent symptoms such as shoulder, neck, or back pain, shoulder grooving, or intertrigo. This condition can be improved and the associated signs and symptoms can be alleviated by reduction mammaplasty surgery.

EVIDENCE SUMMARY

The following literature appraisal is focused on the investigational technique of reduction mammaplasty by liposuction alone. In order to understand the impact on health outcomes of reduction mammaplasty by liposuction alone, prospective clinical trials are needed, comparing liposuction with standard reduction mammaplasty. These comparisons are necessary in order to understand the safety and efficacy of liposuction and to determine whether liposuction offers advantages over conventional surgical procedures with respect to patient satisfaction, complications, durability, and cosmesis.

While there are some published articles concerning the use of liposuction as the sole procedure for breast reduction, none compare the outcomes of liposuction alone to standard excisional reduction mammaplasty.[2-11] Examples of these articles are detailed below:

Moskovitz (2007) conducted a study of liposuction alone for treatment of macromastia in twenty-four African-American women due to their high risk for complex scar formation following standard excision mammaplasty.[8] The mean aspirate was 1075 cc of fat per breast; however, the before and after liposuction pictures indicate that the participants continued to support large breasts. Outcome measures included the SF-36, EuroQol, Multidimensional Body-Self Relations Questionnaire, McGill Pain Questionnaire and Breast-Related Symptoms Questionnaire. Statistical analysis demonstrated a significant improvement in breast-related symptoms and pain. This was a relatively small, non-randomized trial and patients were not blinded to the intervention. Conclusions concerning the effect of liposuction alone on breast-related symptoms in patients with macromastia cannot be made.

Jakubietz (2011) reported the indications and limitations of this procedure compared to conventional surgical excision.[9] Advantages included selective removal of fat, ease of procedure, and the advantages of less invasive procedures such as faster recovery time and reduced scarring. One disadvantage of liposuction alone included the inability to correct shape and ptosis, making aesthetic results optimal only for young patients. In addition, there are concerns about the extent to which subsequent breast imaging may be impaired, and the possible spread of cancer cells. The authors recommended caution when considering use of this technique.

In summary, high-quality evidence on the use of liposuction for reduction mammaplasty has not been identified; comparative trials of sufficient size and duration are needed before any conclusions can be made about the use of this technique for breast reduction.

PRACTICE GUIDELINE SUMMARY

AMERICAN SOCIETY OF PLASTIC SURGEONS

In 2011, the American Society of Plastic Surgeons (ASPS) released an evidence-based clinical practice guideline on the use of reduction mammaplasty.[12] This guideline was updated and reaffirmed in 2022.[13] Based on high quality evidence, the ASPS strongly recommends that "postmenarche female patients presenting with breast hypertrophy should be offered reduction mammaplasty surgery as first-line therapy over nonoperative therapy based solely on the presence of multiple symptoms rather than resection weight." The guideline goes on to state that "reduction mammaplasty surgery is considered standard of care for symptomatic breast hypertrophy." The companion document notes that medical records should document the symptoms associated with the hypertrophy the patient has experienced, and lists the following:

- "Documentation may include pain that patient experiences in the neck, back, or breasts related to movement
- Difficulties in daily activities such as grocery shopping, banking, using transportation, preparing meals, feeding, showering, etc
- Documentation of any secondary complications or infections that may have occurred as a result of hypertrophy or macromastia including intertrigo, chronic rash, cervicalgia, dorsalgia, or kyphosis
- Documentation of prior procedures or therapies may be included but not required for approval
- Photographs demonstrating the patient’s breast appearance, possible shoulder grooves and kyphosis can be included in the medical documentation
- Significant scientific evidence supports non-operative therapies should not be required prior to approval of the procedure."

SUMMARY

Medically Necessary

Female breast hypertrophy, or macromastia, is the development of abnormally large breasts, which can cause medical problems. There is enough research to show that reduction mammaplasty can improve health outcomes for certain patients with this condition. Therefore, reduction mammaplasty may be considered medically necessary when policy criteria are met.

Not Medically Necessary

Female breast hypertrophy, or macromastia, is the development of abnormally large breasts, which can cause medical problems. There is enough research to show that reduction mammaplasty can improve health outcomes for certain individuals with this condition. Therefore, reduction mammaplasty may be considered medically necessary when policy criteria are met. Reduction mammaplasty as treatment for macromastia is considered not medically necessary when policy criteria are not met.

Gynecomastia refers to the benign enlargement of the male breast, mainly due to excessive growth of glandular tissue. Reduction mammaplasty (partial removal) for the treatment of gynecomastia is considered not medically necessary, as the current standard of care is for the removal of most or all glandular tissue.

Investigational

There is not enough research to show that liposuction mammaplasty can improve health outcomes more than traditional mammaplasty techniques. Therefore, reduction mammaplasty by liposuction alone is considered investigational.

REFERENCES

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http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Reduction%20Mammaplasty_%20Evidence%20Based%20Guidelines_v5.pdf.
13. Perdikis G, Dillingham C, Boukovalas S, et al. American Society of Plastic Surgeons Evidence-Based Clinical Practice Guideline Revision: Reduction Mammaplasty. *Plast Reconstr Surg.* 2022;149(3):392e-409e. PMID: 35006204

CODES

Note: Nipple/areola reconstruction (CPT 19350) is considered an included component of CPT 19318 and not separately allowable.

Codes	Number	Description
CPT	15877	Suction assisted lipectomy; trunk
	19318	Breast reduction
HCPCS	None	

Date of Origin: *January 1996*