Reduction Mammaplasty (Mammoplasty)

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual but they may also be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

A reduction mammoplasty is a surgical procedure most frequently associated with macromastia (breast hypertrophy), which is an increase in the volume and weight of breast tissue relative to the general body habitus. Because breast hypertrophy may adversely affect other body systems (e.g., musculoskeletal, respiratory, and integumentary), a reduction mammoplasty may be performed when signs or symptoms have not responded to non-surgical interventions. In addition, unilateral hypertrophy may result in symptoms following contralateral mastectomy. It may also be performed to treat breast carcinomas.

MEDICARE ADVANTAGE POLICY CRITERIA

Note:

- This policy is not applicable when used for unilateral hypertrophy reconstruction after partial or complete mastectomy, which is addressed in the *Reconstructive*

Breast Surgery, Mastopexy, and Management of Breast Implants policy (see Cross References)

- This policy is not applicable when used for treatment of gender dysphoria, which is addressed in the *Gender Affirming Interventions for Gender Dysphoria* policy (see Cross References).

CMS Coverage Manuals

None

National Coverage Determinations (NCDs)

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

None

Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

Plastic Surgery (L35163) *(Companion article is A57221, which can be accessed directly from the LCD)*

Links to prior versions can be found at the bottom of the LCD.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- Primary reason for the procedure;
- If the primary indication is macromastia (breast hypertrophy), documentation must include signs and/or symptoms experienced ***AND*** they must be the result of the enlarged breasts;
- Non-surgical interventions that have been attempted and their respective outcomes;
- The clinical records must document the amount of tissue reduction anticipated and the rationale on how that amount was determined.

CROSS REFERENCES

1. Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. M-153
2. Cosmetic and Reconstructive Procedures, Surgery, Policy No. M-12
3. Reconstructive Breast Surgery, Mastopexy, and Management of Breast Implants, Surgery, Policy No. M-40
4. Adipose-derived Stem Cell Enrichment in Autologous Fat Grafting to the Breast, Surgery, Policy No. M-182

REFERENCES

1. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §120 – Cosmetic Surgery
2. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

CODING

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