Medical Coverage Policy

Policy Number – MP21-013E

Original review date – 11/17/2021

Effective date – 05/22/2024

Reduction mammoplasty

Definition

Macromastia, or breast hypertrophy, is an excessive increase in the volume and weight of breast tissue, in a manner which is disproportionate to the body. Breast hypertrophy can be unilateral or bilateral. Heavy breasts can interfere with daily activities due to severe back or shoulder pain, as well as cause skin breakdown under the breasts.

Reduction mammoplasty is a surgical procedure that removes excessive breast tissue, whilst still preserving a natural, balanced appearance with normal location of the nipple and areola. The goals of this surgery are to relieve the symptoms caused by heavy breasts.

Policy statement

Disclaimer: This policy is applicable to TRICARE Prime and Select beneficiaries and may not apply to Active Duty Service Members (ADSM) under Supplemental Health Care Program (SHCP) or TRICARE Prime Remote (TPR) in accordance with TRICARE Operations Manual (TOM) Chapter 17, Section 3. Please review TOM Chapter 17, Section 3, Paragraph 2.0 onwards, regarding SHCP coverage and any TRICARE-specific exclusions included in this coverage policy to accurately determine the benefit for ADSMs.

Reduction mammoplasty may be covered if ALL the following criteria are met:

I. Female with macromastia and all of the following:
   a. Symptoms that affect daily living which include at least one of the following:
      i. Severe neck, shoulder, or back pain attributable to macromastia
      ii. Ulnar paresthesia
      iii. Shoulder grooving or ulceration
      iv. Intertrigo under the breasts
   b. Mammography for women 40 years and older which is negative for suspected cancer, within 12 calendar months prior to date of reduction mammoplasty

II. Contralateral symmetry surgery performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast

Coverage note

Photo documentation and estimate of breast tissue to be removed, based on the Schnur scale may be requested as part of coverage determination.

Schnur Scale

Body Surface Area Meters squared	**Lower 22%** Minimum weight of tissue (grams) to be removed per breast
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1,068
2.35	1,167
2.40	1,275
2.45	1,393
2.50	1,522
2.55	1,662
>2.55	**Medical Director Review Required**

TRICARE Policy Manual (TPM) Chapter 4, Section 5.2

3.2 Payment may be made for contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammaplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast).

Note: Services related to the augmentation, reduction, or mastopexy of the contralateral breast in post-mastectomy reconstructive breast surgery are not subject to the regulatory exclusion for mammaplasties performed primarily for reasons of cosmesis.

TRICARE Policy Manual Chapter 4, Section 5.4

Note: There are wide variations in the range of normal individual height, body weight and associated breast sizes; the amount of breast tissue that must be removed to relieve symptoms therefore varies with the height and weight of each patient (e.g., a small-statured person will need proportionally less breast tissue removed to alleviate signs and symptoms of macromastia than a larger person). Guidelines for determining whether breast reduction is medically necessary include the Schnur sliding scale [Schnur, Paul L, et al, "Reduction Mammaplasty: Cosmetic or Reconstructive Procedure?" Annals of Plastic Surgery, September 1991; 27 (3): 232-7] and InterQual guidelines.

3.0 POLICY

3.1 Reduction mammaplasty is covered when signs and symptoms of macromastia are functionally significant.

Note: Symptoms may include postural backache, upper back and neck pain, and ulnar paresthesia. Appropriate physical findings are "true" hypertrophy, and shoulder grooving and intertrigo. Signs may include poor posture and the inability to participate in normal physical activities. These may be functionally significant in some individuals.

3.2 Photo-documentation may be requested as part of a coverage determination.

4.0 EXCLUSIONS

4.1 Reduction mammaplasties solely to treat fibrocystic disease of the breast.

4.2 Reduction mammaplasty performed solely for cosmetic purposes.

4.3 Mastopexy surgery.

Coding information

19318	Breast Reduction

References

1. TRICARE Policy Manual Chapter4, Section 5.4 TRICARE Manuals - Manual Information (health.mil)
2. MCG Health. Reduction Mammoplasty. Ambulatory Care. 27th edition. ACG: A-0274 (AC). Last reviewed: 09/21/2023
3. Uptodate Inc. Overview of breast reduction. Last reviewed April 19, 2023
4. Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD) L38914. Cosmetic and Reconstructive Surgery. Effective Date 07/11/2021
5. Centers for Medicare and Medicaid Services. Local Coverage Article. A58573 Billing and Coding: Cosmetic and Reconstructive Surgery. Effective Date 07/11/2021

Revision History
May 2024: Updated coverage criteria and references
August 2023: Updated references

Approved by:

Joseph F. McKeon, MD, MPH

Chief Medical Officer

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