Medicare Advantage Policy Manual **Policy ID:** M-SUR60

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.

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 the Centers of Medicare and Medicaid Services (CMS) policies, when available. 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 CMS guidance for a requested service or procedure, the health plan may apply their Medical Policy Manual or MCG™ criteria, both of which are developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Medicare and EOCs exclude from coverage, among other things, services or procedures considered to be investigational, cosmetic, or not medically necessary, and 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.

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. This scenario is addressed in the *Reconstructive*

Breast Surgery, Mastopexy, and Management of Breast Implants policy (Medicare Advantage medical policy, Surgery, Policy No. M-40) (see cross references)
- This policy is not applicable when used for treatment of gender dysphoria. This scenario is addressed in the *Gender Affirming Interventions for Gender Dysphoria* policy (Medicare Advantage medical policy, Medicine, Policy No. M-153) (see cross references).

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	Plastic Surgery (L37020) **Scroll to the "Public Version(s)" section at the bottom of the LCD for links to prior versions if necessary.

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 (i.e., breast carcinoma, breast hypertrophy, etc.);
- 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; and,
- The clinical records must document the amount of tissue reduction anticipated and the rationale on how that amount was determined.

REGULATORY STATUS

As a surgical procedure, reduction mammaplasty is not subject to U.S. Food and Drug Administration (FDA) review or approval.

CROSS REFERENCES

Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. M-153

Cosmetic and Reconstructive Procedures, Surgery, Policy No. M-12

Reconstructive Breast Surgery, Mastopexy, and Management of Breast Implants, Surgery, Policy No. M-40

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	Reduction mammaplasty
HCPCS	None	

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*