



# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP068**

**Section: Medical Benefit Policy**

**Subject: Reduction Mammoplasty**

## Applicable line of business:

<b>Commercial</b>	<b>x</b>	<b>Medicaid</b>	<b>x</b>
<b>Medicare</b>	<b>x</b>	<b>ACA</b>	<b>x</b>
<b>CHIP</b>	<b>x</b>		

### I. Policy: Reduction Mammoplasty

### II. Purpose/Objective:

To provide a policy of coverage regarding Reduction Mammoplasty

### III. Responsibility:

- A. Medical Directors
- B. Medical Management

### IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

#### Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

#### Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

#### CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

#### Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

## V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

## Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

## DESCRIPTION:

Reduction mammoplasty is a surgical procedure to remove substantial breast tissue (skin and underlying glandular tissue).

## INDICATIONS:

Breast reduction of the non-affected breast following mastectomy to achieve symmetry is considered medically necessary and covered in accordance with the Women's Health and Cancer Rights Act (WHCRA).

For members enrolled in product lines in which reduction mammoplasty for the treatment of complications secondary to macromastia is not specifically excluded, **PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OF DESIGNEE IS REQUIRED**

## CRITERIA:

For those members enrolled in product lines in which reduction mammoplasty for the treatment of complications secondary to macromastia is not specifically excluded, the following criteria will be used to determine eligibility for coverage.

- a Physician provided documentation of a diagnosis of macromastia; **and**
- b Severe chronic skin breakdown unresponsive to medical management; **or**
- c Documented chronic pain due to macromastia defined by **all** of the following criteria
  - Pain that affects the activities of daily living for a minimum of 6 months
  - Documentation in the medical record to involve one of the following:
    - Upper back pain and/or
    - Neck/shoulders pain
    - Acquired kyphosis on X-ray due to weight of the breasts
    - Upper extremity parasthesia
    - Ulceration or pain/grooving from cutting of bra straps

**and**

- c For members 40 years of age or older, a mammogram that was negative for cancer has been completed within the year prior to the planned reduction mammoplasty;

**and**

d Average weight of tissue planned to be removed in each breast, is above the 22nd percentile\* on the Modified Schnur Sliding Scale based on the patient's body surface area (BSA)\*\*. (See Attachment A for Listing)

\*\*To calculate body surface area (BSA):

$$BSA (m^2) = ([height (cm) \times weight (kg)]/3600)^{\frac{1}{2}}$$

**\*NOTE:**

If the proposed total grams of tissue is less than the 22<sup>nd</sup> percentile but greater than the 5<sup>th</sup> percentile on the Modified Schnur scale, clinical documentation of circumstances to support the proposed tissue removal must be submitted for determination of medical necessity.

If the proposed total grams of tissue is less than the 5<sup>th</sup> percentile on the Modified Schnur scale, the procedure will be considered to be cosmetic and therefore **NOT COVERED**.

For treatment of gynecomastia, see **MP055 Mastectomy for Gynecomastia**.

For the treatment of gender dysphoria, see **MP307 Gender Dysphoria and Gender Confirmation Treatment**

**EXCLUSIONS:**

Breast reduction to improve appearance without improving a functional/physiologic impairment is considered cosmetic and **NOT COVERED**.

Reduction mammoplasty to correct an anatomical congenital anomaly without improving or restoring physiologic function is considered cosmetic and **NOT COVERED**.

**Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

**CODING ASSOCIATED WITH: REDUCTION MAMMAPLASTY**

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

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**LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.**

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This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 2/23/93

**Revised:** 3/96, 9/99, 3/02, 3/04, 3/06, 3/07, 3/10 (removed link), 8/11(criteria updated); 2/16 (revised criteria), 7/16 (Gender Language); 2/20 (revised criteria); 2/21 (clarified indications; added cross-reference, exclusions), 2/24 ( add cross reference)

**Reviewed:** 3/03, 3/08, 3/09, 3/11, 7/12, 7/13, 7/14, 2/17, 2/18, 2/19, 2/22, 2/23; 2/25

**CMS UM Oversight Committee Approval:** 12/23, 5/24, 4/25

*Attachment A*

**Modified Schnur Sliding Scale  
Body Surface Area and Cutoff Weight of Breast Tissue Removed**

<b>Body Surface Area (m<sup>2</sup>)</b>	<b>Lower 5<sup>th</sup> Percentile</b>	<b>Minimum Grams of Breast Tissue to be Removed (per Breast) 22<sup>nd</sup> Percentile</b>
1.35	127	199
1.40	139	218
1.45	152	238
1.50	166	260
1.55	181	284
1.60	198	310
1.65	216	338
1.70	236	370
1.75	258	404
1.80	282	441
1.85	308	482
1.90	336	527
1.95	367	575
2.00	401	628
2.05	439	687
2.10	479	750
2.15	523	819
2.20	572	895
2.25	625	978
2.30	682	1068
2.35	745	1167
2.40	814	1275
2.45	890	1393
2.50	972	1522

<b>2.55</b>	<b>1062</b>	<b>1662</b>
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**\*Modified Schnur Sliding Scale (Schnur, et al., 1991)(Schnur PL, 1999)**

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.