sy Choice Health Plan

Harmony Health Plan of Illinois

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

Reduction Mammoplasty for Adolescents

Policy Number: HS-322

Original Effective Date: 9/27/2017

Revised Date(s): N/A

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Reduction mammoplasty is the surgical reduction of breast size. It was developed as a means of alleviating physical and emotional symptoms associated with excessive breast size and breast ptosis. Members desiring reduction mammoplasty may seek surgery to alleviate difficulty in finding clothing, sleeping, or exercising or to relieve hand and arm pain. Surgery may also be sought by patients who desire a purely cosmetic result. The goal of the surgery is to create a natural, balanced appearance and normal location of the nipple and areola with minimal scarring, while maintaining normal sensation. Several procedures are available to accomplish breast reduction, each with its unique combination of skin incisions and resection patterns and approach to breast reshaping. Two surgical approaches to reduction mammoplasty are currently popular: Wise pattern reduction mammoplasty and vertical pattern breast reduction. The Wise pattern reduction mammoplasty is most commonly used in the United States, and the vertical

pattern breast reduction is more popular in Europe. Both are pedicle-based procedures, with the Wise pattern scars entirely below the nipple and the vertical pedicle scars above the nipple. A crescent-shaped mass of tissue is removed from the inferior portion of each breast, and the skin is resected and sutured. Both grafting and pedicle-based techniques are used in cases where it is necessary to reposition the nipple-areola complex. These procedures seek to preserve the blood and nerve supply to the nipple-areola complex and create a symmetrical and natural appearance, while reducing breast volume and weight. Care is also taken to avoid scars that may be visible when the patient is clothed.

Members may return home on the day of surgery, with or without surgical drains in place. The breasts are kept firmly supported until swelling subsides. The skin is inspected daily for signs of infection or hematoma. Members are instructed to avoid strenuous activity for several weeks. It may take up to 6 months for the shape of the breasts and any scarring to stabilize completely. Since scarring of the breast will not permit comparison with earlier studies, mammography should be performed at that point to serve as a baseline for future evaluation. Evidence from randomized controlled and nonrandomized demographically matched controlled studies is sufficient to conclude that reduction mammoplasty is effective for the relief of symptoms of macromastia, with relatively few serious complications. In all of the reviewed studies, reduction mammoplasty significantly improved health-related quality of life and most functional measures, while reducing pain and breast-associated symptoms.[1]

POSITION STATEMENT

Applicable To:

☑ Medicaid

Exclusions

Reduction mammoplasty **is NOT covered** when performed for either of the following reasons:

1) Surgery is being performed to treat psychological symptomatology or psychosocial complaints, in the absence of significant physical, objective signs; **OR,**

2) Surgery is being performed for the sole purpose of improving appearance.

Suction lipectomy or ultrasonically-assisted suction lipectomy (liposuction) as a sole method of treatment for symptomatic macromastia **is NOT a covered benefit.**

Coverage

Reduction Mammoplasty **is considered medically necessary** when ALL of the following criteria are met:

1) Member is female under the age of 18 and has clinical evidence documenting physical development is complete by documentation of 18 months post-attainment of Tanner V pubertal staging; **AND,**

2) There is a diagnosis of Macromastia by physical examination; **AND,**

3) TWO of the following conditions which negatively affect activities of daily living are present and are refractory to at least 3 months of conservative care*******:

- Chronic breast pain due to weight of breast; **OR,**
- Intertrigo, dermatitis, eczema, or hidradenitis at the inframammary fold, unresponsive to medical management: **OR,**
- Upper back, neck and shoulder pain; **OR,**
- Thoracic kyphosis, acquired; **OR,**
- Shoulder grooving from bra straps; **OR,**
- Upper extremity paresthesia due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area; **OR,**
- Headache affecting activities of daily living.

******* Conservative care may be classified as the following: oral analgesic use, compress use, massage, supportive garment and back brace use, physical therapy and/or correction of obesity.

CODING

Covered CPT®* Codes
19318 Reduction mammoplasty

Non-Covered CPT®* Codes
15877 Suction assisted lipectomy; trunk
NOTE: Not covered when performed as a sole method of treatment for symptomatic macromastia

Covered ICD-10 Diagnosis Code
N62 Hypertrophy of breast

Covered ICD-10-PCS Codes
0HBT0ZZ Excision of right breast, open approach
0HBT3ZZ Excision of right breast, percutaneous approach
0HBU0ZZ Excision of left breast, open approach
0HBU3ZZ Excision of left breast, percutaneous approach
0HBV0ZZ Excision of bilateral breast, open approach
0HBV3ZZ Excision of bilateral breast, percutaneous approach

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. Reduction mammoplasty. Hayes Directory Web site. http://www.hayesinc.com. Published December 18, 2008 [archived January 18, 2014]. Accessed August 7, 2017.
2. Schnur PL, Hoehn JG, Ilstrup DM, Cahoy MJ, Chu CP. (1991). Reduction mammaplasty: cosmetic or reconstructive procedure? *Annals of Plastic Surgery, 27*, 232-237.
3. Recommended insurance coverage criteria for third party payers: reduction mammaplasty. American Society of Plastic Surgeons Web site. http://www.plasticsurgery.org. Published March 9, 2002. Accessed August 7, 2017.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
9/7/2017	• Approved by MPC. New policy for reduction mammoplasty for adolescents only.