ASPS Recommended Insurance Coverage Criteria for Third-Party Payers

Reduction Mammaplasty

Approved by the Executive Committee of the American Society of Plastic Surgeons®, May 2011.
Reaffirmed: March 2021

BACKGROUND


Reduction mammaplasty is a procedure performed for symptomatic breast hypertrophy in more than 100,000 patients a year. There is an extensive body of evidence demonstrating the efficacy of reduction mammaplasty in reducing both physical and psychological symptoms in patients with symptomatic breast hypertrophy.

HISTORY

Prior to the 1990s, few health care insurance companies compensated surgeons for reduction mammaplasty as they considered it a cosmetic procedure. As a result, the American Society of Plastic and Reconstructive Surgeons sent several members to visit the Medical Directors of a number of major health care insurance companies. The unanimous response from the Medical Directors was that there was nothing in the medical literature substantiating the health benefit of reduction mammaplasty. As a result of these findings, Schnur and Hoehn published a study suggesting criteria for insurance coverage. The suggested criteria became known as “The Schnur Sliding Scale.” A large number of insurance companies adopted the Schnur Sliding Scale as their standard for payment for reduction mammaplasty.
Many of these companies continue to use this sliding scale to this day. To prove medical necessity, Schnur and Schnur\textsuperscript{32}, reviewed a large number of patients at the Mayo Clinic who had undergone reduction mammaplasty. In this study, 94.2\% of patients reported that the procedure was completely or very successful in relieving their symptoms. In 2002 Collins, Kerrigan, et al.\textsuperscript{4}, reported that reduction mammaplasty significantly improved the symptoms of macromastia. Their surprise findings were that the patients received the same relief of symptoms regardless of body size or amount of breast tissue removed. An article published in 2002 by Kerrigan, Collins, Kim, Schnur, Wilkins, Cunningham, and Lowery\textsuperscript{21} recommended that a constellation of symptoms of macromastia be used as criteria for Insurance coverage by third-party payers instead of the Schnur Sliding Scale. The Schnur Sliding Scale made the assumption that the larger the macromastia, the more severe the symptoms. In their 2002 article, Collins, Kerrigan, et al.\textsuperscript{4} proved this assumption untrue. The recommendation for insurance coverage by third-party payers is a modification of the Kerrigan et al. article\textsuperscript{21} and, therefore, should be used in place of the Schnur Sliding Scale.

**DEFINITIONS**

Symptomatic breast hypertrophy is a medical condition that causes a significant health burden for patients.\textsuperscript{11, 12, 13} There is no evidence that non-operative management provides effective long-term relief of symptoms.

Instead, patients have an increased obesity risk associated with difficulty exercising due to breast size impacting posture and upper spinal movement. Symptomatology may also require chronic administration of pain medication, emergency room evaluations, physical therapy, and missed work and/or school days.\textsuperscript{11, 12, 13}

Reduction mammaplasty surgery is considered standard of care for symptomatic breast hypertrophy. Several studies have demonstrated physical and psychological benefits, including improvement in degenerative spine disease, pain, functional capacity, depression, patient satisfaction, psychosocial, and sexual well-being\textsuperscript{14, 3, 4, 5, 15, 6, 7, 8, 9, 10}. Quantifiable data using Breast-Q Reduction surveys have shown validated, improved outcomes and satisfaction among women undergoing reduction mammaplasty\textsuperscript{16, 17, 13}.

**Operative Treatment is Effective**
Two studies reviewed compare early surgery versus delayed surgery\textsuperscript{18, 8}. The first high quality prospective randomized study examined the effect of bilateral reduction mammoplasty on depression and anxiety\textsuperscript{18}. Women were randomized to either early operation (n= 36) or delayed (n=37). The presence of clinical anxiety and depression were assessed using the Hospital Anxiety Depression Score (HADS). Those women who had earlier surgery (within six weeks of assessment) demonstrated significantly less (p=<0.001) clinical anxiety and depression than those receiving delayed surgery\textsuperscript{18}.

An RCT using a modification of the Beck Depression Inventory demonstrated a reduction of depression and anxiety after reduction mammoplasty (moderate quality)\textsuperscript{8}. Details from this study include significant increases in self-esteem (p=0.03), reduced depression (p<0.01) and anxiety (p=0.04) in women who had surgery (n=29) versus conservative treatment (n = 35).

Another high-quality randomized study examined the benefits to quality of life following bilateral reduction mammoplasty using multiple Quality of Life validated self-reported scales\textsuperscript{6}. The delayed surgery (control group) underwent a trial of non-surgical treatment that included medication, use of special brassieres and physical therapy (a handout on upper body exercises to be completed three times per week). Thirty-six women underwent early surgery. The early surgery group demonstrated significant improvements in emotional stability and extroversion when compared to the control group (n=37). There was strong support for a recommendation on the use of validated Quality of Life questionnaires to assess patient experience of care and emotional well-being which were supported by the previous ASPS reduction mammoplasty guideline\textsuperscript{19}

**Resection Weight:**

Numerous studies have demonstrated the lack of correlation between the amount of weight resection and symptomatic relief\textsuperscript{4, 20, 21, 22, 23}. In two studies, Spector et al\textsuperscript{9, 10} found that a reduction mammoplasty removing less than 500 gm of tissue offered symptom relief and improved quality of life. The Breast Reduction Assessment of Value and Outcomes (BRAVO) study compared quality of life outcomes in post-operative patients with resection weights less...
than 500 gm and patients with resection weights greater than 500 gm. The two groups experienced equivalent improvement across five validated measures of health burden. The evidence demonstrates that resection weight does not accurately predict patient-oriented outcomes such as alleviation of pain and related symptoms, and should not be the primary determinant of medical necessity.

Evidence indicates that women, across a wide range of breast sizes, experience similar benefits from reduction mammaplasty. According to two prospective studies, women of varying breast sizes, experience similar preoperative symptoms and similar postoperative relief and quality of life improvement regardless of the total resection volume. Even though Reduction Mammaplasty coverage varies by insurance carrier, medical necessity and patient discomfort level should be taken into account when denying/approving the procedure.

POLICY

Based on the thorough evidence review leading to the strong recommendation in the revised clinical practice guideline, it is clear that reduction mammaplasty is extremely effective at reducing hypertrophy related symptoms and improving postoperative quality of life. Insurance coverage criteria for symptomatic breast hypertrophy should be based upon documentation of at least two symptoms (see below) regardless of body weight or weight of breast tissue removed. The documentation of at least two symptoms is supported by a prospective study examining the medical necessity of reduction mammaplasty. Of women presenting for surgical correction of symptomatic breast hypertrophy, 87.6% listed at least two out of seven breast-related physical symptoms occurring all or most of the time, as compared with 2% of women with normal breast size (C or smaller).

**Documentation:**

Documentation is key when supporting coverage for breast reduction mammaplasty. The Medical Record should document the symptoms associated with the hypertrophy the patient has experienced.
Records should include the presenting symptoms.

- Documentation may include pain that patient experiences in the neck, back, or breasts related to movement.
- Difficulties in daily activities such as grocery shopping, banking, using transportation, preparing meals, feeding, showering, etc.
- Documentation of any secondary complications or infections that may have occurred as a result of hypertrophy or macromastia including intertrigo, chronic rash, cervicalgia, dorsalgia, or kyphosis.
- Documentation of prior procedures or therapies may be included but not required for approval.
- Photographs demonstrating the patient’s breast appearance, possible shoulder grooves and kyphosis can be included in the medical documentation.
- Significant scientific evidence supports non-operative therapies should not be required prior to approval of the procedure.

**ICD-10 Coding:**

Physicians should document the severity of the symptoms of breast hypertrophy (ICD-10-CM: N62) and impact on health related quality of life as measured by a breast specific questionnaire which includes at least two of the following signs/symptoms:

- Chronic breast pain (ICD-10-CM: N64.4) due to weight of the breasts
- Intertrigo (ICD-10-CM: L30.4) unresponsive to medical management
- Upper back, neck, and shoulder pain (ICD-10-CM: M54.6, M54.2, M53.82, M25.511 –M25.519)
- Backache, unspecified (ICD-10-CM: M54.89, M54.96)
- Thoracic kyphosis, acquired (ICD-10-CM: M40.04, M40.14, M40.204, M40.294)
- Shoulder grooving from bra straps (ICD-10-CM: M95.4)
• Upper extremity paresthesia (ICD-10-CM: R20.0-R20.9) due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area

• Headache (ICD-10-CM: R51)

• Congenital breast deformity (ICD-10-CM: Q38.0-Q38.8)

**CPT Coding:**

• 19318 Unilateral reduction mammoplasty

• 19318-50 Opposite breast reduction mammoplasty
**Figure 1. American Society of Plastic Surgeons Strength of Aggregate Evidence and Recommendations**

<table>
<thead>
<tr>
<th>Strength of Evidence</th>
<th>Recommendation</th>
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<tr>
<td><strong>Strong (High Quality) Evidence</strong></td>
<td>Strong Recommendation</td>
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<tr>
<td>Evidence from two or more “High” quality studies with consistent findings for recommending for or against the intervention.</td>
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| **Moderate Quality Evidence** | Moderate Recommendation |
| Evidence from two or more “Moderate” quality studies with consistent findings, or evidence from a single “High” quality study for recommending for or against the intervention. |

| **Low Quality Evidence** | Weak Recommendation |
| Evidence from one or more “Low” quality studies with consistent findings or evidence from a single “Moderate” quality study recommending for or against the intervention. |

| **Very Low Quality Evidence** | No Recommendation may be made |
| Evidence from one or more “Very Low” quality studies with consistent findings or evidence from a single “Low” quality study recommendation for or against the intervention. |
### Table 2. Recommendation Definitions and Levels of Adherence

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<th>Level</th>
<th>Definition</th>
<th>Adherence Advice</th>
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<tr>
<td><strong>Strong recommendation</strong></td>
<td>A particular action is favored because anticipated benefits clearly exceed harms (or vice versa), and quality of evidence is excellent (moderate or strong) or unobtainable.</td>
<td>Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.</td>
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<td><strong>Moderate recommendation</strong></td>
<td>A particular action is favored because anticipated benefits clearly exceed harms (or vice versa), and the quality of evidence is good but not excellent (or is unobtainable).</td>
<td>Clinicians would be prudent to follow a moderate recommendation but should remain alert to new information and sensitive to patient preferences.</td>
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<td><strong>Weak recommendation</strong></td>
<td>A particular action is favored because anticipated benefits clearly exceed harms (or vice versa), but the quality of evidence is low or very low.</td>
<td>Clinicians would be prudent to follow a weak recommendation but should remain alert to new information and very sensitive to patient preferences.</td>
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<td><strong>Option</strong></td>
<td>An option is provided when the aggregated data shows evidence of both benefit and harm that appear similar in magnitude for any available courses of action</td>
<td>Clinicians should consider the options in their decision making, but patient preference may have a substantial role.</td>
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REFERENCE LIST


