



# Guidelines for Medical Necessity Determination for Reduction Mammoplasty

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This edition of Guidelines for Medical Necessity Determination (Guidelines) identifies the clinical information MassHealth needs to determine medical necessity for reduction mammoplasty (breast reduction). These Guidelines are based on generally accepted standards of practice, review of the medical literature, and federal and state policies and laws applicable to Medicaid programs. Other breast surgeries are covered in other MassHealth Guidelines.

Providers should consult MassHealth regulations at 130 CMR 433.000 (physician services), 415.000 (acute inpatient hospital services), 450.000 (administrative and billing regulations), and Subchapter 6 of the *Physician Manual* for information about coverage, limitations, service conditions, and other prior authorization (PA) requirements applicable to this service.

Providers serving members enrolled in a MassHealth-contracted accountable care partnership plan (ACPP), managed care organization (MCO), integrated care organization (ICO), senior care organization (SCO), or a program of all-inclusive care for the elderly (PACE), should refer to the ACPP's, MCO's, ICO's, SCO's, or PACE's medical policies for covered services.

MassHealth requires PA for reduction mammoplasty. MassHealth reviews requests for PA on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

## 1

### SECTION I. GENERAL INFORMATION

Reduction mammoplasty can be used to treat female symptomatic breast hypertrophy after conservative treatments have failed. Reduction mammoplasty involves removal of glandular, fatty, and skin tissue from the breast. Women presenting various forms of breast hypertrophy (for example, macromastia or gigantomastia) accompanied by persistent clinical signs and symptoms that adversely affect health are the principal candidates for breast reduction. According to the American Society of Plastic Surgeons, normal breast size is described as size C or smaller. MassHealth considers approval for coverage of breast reduction on an individual, case-by-case basis, in accordance with 130 CMR 450.204: *Medical Necessity*, when needed to alleviate or correct medical problems caused by excessive breast tissue.

## 2

### SECTION II: CLINICAL GUIDELINES

#### A. CLINICAL COVERAGE

MassHealth bases its determination of medical necessity for reduction mammoplasty on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure, including post-operative recovery. These clinical coverage criteria include, but are not limited to, the following.

1. The member has been diagnosed with one or more of the medical conditions below in 1.a through 1.f and meets the condition-specific criteria set forth below:

- a) The member is female.
  - b) A comprehensive medical history and complete physical exam (including breast exam) has been conducted by the referring health care provider.
  - c) The member has a diagnosis of breast hypertrophy, or gigantomastia or macromastia (size D or higher).
  - d) At least one of the following criteria (i, ii, iii, or iv) is met:
    - i. Back pain unresponsive to conservative treatments for three months within a year prior to this request. Conservative treatment must include at least three months of (a) a documented trial of analgesics, AND (b) physical therapy or chiropractic treatment, AND (c) use of support wear for the breasts.
    - ii. Neck pain unresponsive to conservative treatments for three months within a year prior to this request. Conservative treatment must include at least three months of (a) a documented trial of analgesics, AND (b) physical therapy or chiropractic treatment, AND (c) use of support wear for the breasts.
    - iii. Shoulder pain unresponsive to conservative treatments for three months within a year prior to this request. Conservative treatment must include at least three months of (a) a documented trial of analgesics, AND (b) physical therapy or chiropractic treatment, AND (c) use of support wear for the breasts.
    - iv. Persistent severe intertrigo in the inframammary fold unresponsive to documented prescribed medication for at least three months within a year prior to this request.
  - e) The treating surgeon must specify the amount of tissue to be removed from each breast and the prognosis for improvement of symptoms pertinent to breast hypertrophy, or gigantomastia or macromastia.
  - f) Other etiologies of the symptoms listed above have been excluded.
  - g) In addition, women age 40 and older are required to have a negative screening mammogram within two years of the planned reduction mammoplasty.
2. Clinical Coverage for Adolescents (age 15 through 17): Reduction mammoplasty surgery may be medically necessary for individuals age 15 through 17 when all of the following criteria (a through c) are met:
- a) The clinical coverage criteria in Sections II. A. 1 (a through f) are met.
  - b) The member has completed puberty (Tanner stage V).
  - c) The member has had at least one year history of growth stabilization evidenced by a minimum of four visits with documented heights or puberty completion as shown on wrist radiograph read by a radiologist.

**B. NONCOVERAGE**

- 1. Reduction mammoplasty is not covered for normal sized breasts as described by the American Society of Plastic Surgeons (size C or smaller).
- 2. Reduction mammoplasty is not covered for surgically enlarged breasts with saline or silicone implants. Surgically enlarged breasts are not considered breast hypertrophy, or gigantomastia or macromastia.

3. Reduction mammoplasty is not covered for bilateral reductions of less than 300 grams (1 cup size) per breast.

# 3

## SECTION III: SUBMITTING CLINICAL DOCUMENTATION

- A. Requests for PA for reduction mammoplasty must be accompanied by clinical documentation that supports the medical necessity of this procedure.
- B. Documentation of medical necessity must include all of the following:
  1. The primary diagnosis breast hypertrophy or gigantomastia or macromastia as the cause of symptoms.
  2. Diagnoses of co-morbid conditions.
  3. The most recent medical evaluation, including a summary of the medical history and physical exam (including breasts), including the member's age at onset of the condition, duration of the condition, date the member was diagnosed with the condition, the member's current age, weight, height, co-morbid condition(s), and all previous breast surgeries.
  4. Prior treatments that have been tried in managing symptoms. Please include progress notes detailing symptoms, objective findings, assessment and plan. Please include documentation of any physical therapy, chiropractic treatment, use of analgesics, and use of support wear for treatment of breast hypertrophy or gigantomastia or macromastia within the last year.
  5. Results from diagnostic tests pertinent to the diagnosis.
  6. Photo documentation (front and lateral shoulder to waist) confirming breast hypertrophy taken within the last six months.
  7. The definitive surgical treatment plan which specifies the amount of tissue to be removed from each breast and the prognosis for improvement of symptoms.
  8. Evaluation and rule-out of other co-morbid etiologies of the symptoms, including imaging if appropriate. Such evaluation must also address any neurological symptoms that are present.
  9. Results of mammogram performed for women 40 years or older performed within two years of planned reduction mammoplasty.
  10. For adolescents age 15 to 17, documentation that the member has had at least one year history of growth stabilization evidenced by (a) a minimum of four visits with documented heights, or (b) puberty completion as shown on wrist radiograph read by a radiologist.
  11. Other pertinent clinical information that MassHealth may request.
- C. Clinical information must be submitted by the MassHealth-enrolled qualified health professional performing the procedure. Providers are strongly encouraged to submit requests electronically.

Providers must submit the request for PA and all supporting documentation using the [Provider Online Service Center](#) (POSC), or by completing a MassHealth Prior Authorization Request form (using the PA-1 paper form found at [www.mass.gov/masshealth](http://www.mass.gov/masshealth)) and attaching all supporting documentation. The PA-1 form and documentation should be mailed to the address on the back of the form. Questions regarding POSC access should be directed to the MassHealth Customer Service Center at (800) 841-2900.

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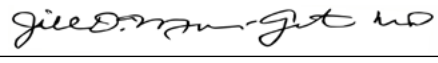
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These Guidelines are based on review of the medical literature and current practice in breast reduction procedures. MassHealth reserves the right to review and update the contents of these Guidelines and cited references as new clinical evidence and medical technology emerge.

This document was prepared for medical professionals to assist them in submitting documentation supporting the medical necessity of the proposed treatment, products, or services. Some language used in this communication may be unfamiliar to other readers; in this case, those readers should contact their health care provider for guidance or explanation.

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Approved by: 

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